

**The Experience of Undergraduate Nursing Students with End of
Life Care and End of Life Care Simulation**

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Statement of Originality

I hereby certify that the work embodied in the thesis is my own work, conducted under normal supervision. The thesis contains no material which has been accepted, or is being examined, for the award of any other degree or diploma in any university or other tertiary institution and, to the best of my knowledge and belief, contains no material previously published or written by another person, except where due reference has been made. I give consent to the final version of my thesis being made available worldwide when deposited in the University's Digital Repository, subject to the provisions of the Copyright Act 1968 and any approved embargo.

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Acknowledgement of Authorship

I hereby certify that the work embodied in this thesis contains published papers/scholarly work of which I am a joint author. I have included as part of the thesis a written declaration endorsed in writing by my supervisor, attesting to my contribution to the joint publications/scholarly work.

By signing below I confirm that Pauline Gillan made a significant contribution to the design, writing and revision and co-authorship of the publications entitled:

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- 3) Gillan, P. C., van der Riet, P. J., & Jeong, S. (2016). Australian nursing students' stories of end-of-life care simulation. *Nursing & Health Sciences*, 18(1), 64–69.

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As I sit down to write my final, and for me, the most important words of my thesis, I am sure my family will collectively take a big deep sigh of relief thinking: FINALLY! It has after all taken me nine years to complete my doctoral studies, adversity and all. But here we are, my family, friends, colleagues and supervisors have all been faultless in their support for me along this very long journey.

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Publications, Conference and Other Presentations During Enrolment

Publications

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Glossary and Definitions of Key Terms

Assistant in Nursing (AIN): a person who has gained a basic nursing qualification (Certificate 3 in Health Services Assistance) through Technical And Further Education Colleges (TAFE) (TAFE Queensland, 2018).

End of Life Care: the term end of life care (physical, spiritual and psychosocial care) refers to the timeframe up to the last 12 months of a person's life, includes when death is imminent, and incorporates care of the patient's body after death (Australian Institute of Health and Welfare [AIHW], 2016). However, for the purposes of this research, end of life care specifically relates to the final phase of life when death is imminent (within hours or days).

End of Life Care Simulation: the use of simulation to provide opportunities for nursing students to care for the patient at the end of life, and an opportunity for students to explore their own beliefs about death and what it means to care for dying patients and their families (Smith-Stoner, 2009a).

Enrolled Nurse (EN): a person who has an appropriate educational preparation and the requisite qualification to be an enrolled nurse with the NMBA, working under the direction and supervision of the registered nurse (Australian Nursing and Midwifery Federation, 2016).

Epistemology: theory of "knowledge and the assumptions and beliefs that we have about the nature of knowledge" and "what is the relationship between the inquirer and the known?" (Robert Wood Johnson Foundation, 2008, para 2).

Fidelity: "the degree to which a simulated learning experience approaches reality" (Meakim et al., 2013, p. S7), this includes the physical environment, conceptual fidelity and psychological fidelity (Smith et al., 2018).

High Fidelity Simulation: uses "technologically lifelike manikins with provision for a high level of realism and interactivity" (Jeffries, 2007, p. 28).

Intensive Residential School: a mandatory designated period of time (2–6 days) for externally enrolled students at the University of New England to attend face-to-face lectures, tutorials, clinical labs and clinical simulations.

Master of Nursing Program (MNP): a Master's degree, specific to the University of New England, attracting international registered nurses to gain qualification as RNs in Australia.

Ontology: philosophy of "existence and the assumptions and beliefs that we hold about the nature of being and existence" (Robert Wood Johnson Foundation, 2008, para 3). It is "the worldview or representation of reality" (Jennings, 2005, p. 211).

Palliative Care: “an approach that improves the quality of life of patients and their families facing the problem associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual” (World Health Organization [WHO], 2018).

Psychological Fidelity: The degree of perceived realism, including psychological factors, emotions, beliefs, and self-awareness of participants in scenarios (Meakim et al., 2013).

Psychological Safety: An implicit or explicit feeling where in simulation “participants can speak up, share thoughts, perceptions, and opinions without the risk of retribution or embarrassment” (Meakim et al., 2013, p. 6S).

Reflection: the “conscious consideration of the meaning and implication of an action” that assimilates “knowledge, skills, and attitudes with pre-existing knowledge” (International Nursing Association for Clinical Simulation and Learning [INACSL], 2011, p. S16).

Registered Nurse (RN): a regulated health professional who demonstrates competence in providing nursing care as specified by registration requirements, standards and codes, relevant legislation and contexts of care (Nursing and Midwifery Board of Australia [NMBA], 2006). An RN in Australia must have successfully completed an approved Bachelor of Nursing degree (three years full time or up to six years part-time) that meets educational standards of the NMBA (2016).

Simulation: “an event or situation made to resemble clinical practice as closely as possible” (Jeffries, 2007, p. 28), through interacting with people, simulators, computers, or task trainers (Smith et al., 2018).

Simulation Debriefing: a facilitator-led activity that immediately follows a simulation experience that encourages participants’ reflective thinking, exploration of emotions, and provides feedback on participants’ performance (Meakim et al., 2013). The purpose is to move toward assimilation and transfer of knowledge to future similar situations (Meakim et al., 2013).

Simulation Pre-briefing: “an information session before the simulation scenario with suggested activities or orientation to the environment” (Chamberlain, 2015, p. 318), and set the stage for the simulation scenario/s and assist participants in achieving simulation objectives (Meakim et al., 2013).

Standardised Patients: actors specifically trained to portray individuals with health conditions, which increases the fidelity or realism of the simulation experience (Fink, Linnard-Palmer, Ganley, Catolico, & Phillips, 2014).

Storied Fragments: fragments of stories derived from participants' field texts; "narrative fragments enacted in storied moments of time and space" (Clandinin & Connelly, 2000, p. 17).

Threads: particular plotlines and patterns that are threaded or woven over time and placed through a participant's narrative account (Clandinin, 2013). In Clandinin's narrative inquiry framework the term threads replaces the term themes.

Undergraduate Nursing Student: a student who is enrolled to undertake studies in a Bachelor of Nursing degree in Australia.

Key to Transcripts

The following abbreviations and conventions have been used throughout the thesis, where excerpts from the participants' transcriptions have been used.

Names:	Pseudonyms are used to refer to participants.
(p.)	Indicates page numbers of individual participant transcripts
[sic]	indicates a word or phrase that may appear strange or incorrect has been written intentionally or has been quoted verbatim and indicates that it exactly reproduces the original.
...	ellipsis indicates intentional omission of a word, sentence, or whole section from a text without altering its original meaning.
()	contains material that serves to clarify or is aside from the main point.
Bold	indicates words, phrases, or sentences relevant to the narrative(s) and thread(s)

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Abstract

End of life care is a daunting experience for undergraduate nursing students who are largely unprepared to undertake quality care for the dying person and their families. Undergraduate nursing curricula often do not provide adequate education on critical aspects of care at the end of life. End of life care simulation is an emerging, innovative and student centred approach that aims to improve nursing students' preparedness for end of life care.

The aims of this research were to: 1) Explore the end of life experiences, personal and professional, of undergraduate nursing students prior to end of life care simulation; 2) Explore experiences of undergraduate nursing students with end of life care simulation; and 3) Investigate the impact of end of life care experiences and end of life care simulation on the undergraduate nursing student.

The research methodology of narrative inquiry was used to address the research aims and unpack the research puzzle of understanding undergraduate nursing students' experiences with end of life care and end of life care simulation. Data were collected from video recorded end of life care simulation, audio taped simulation debriefing, individual semi-structured interviews, and items of meaning brought to interviews. Eighteen undergraduate nursing students enrolled in one rural university in New South Wales, Australia participated in this study. The three dimensional conceptual framework described by Clandinin and Connelly, underpinned by Dewey's philosophy of experience, guided this research and was used to analyse participants' stories.

Students' stories of experience revealed eight significant threads which include: the role of others in shaping death experiences; attending to family at the end of life; theory, practice and experience synergised; managing self, amidst difficult conversations at the end of life; managing self, amidst unfamiliar landscapes of death and dying; defining moments in time; real versus unreal landscapes in simulation; and finding comfort amidst learning and working together.

Arising from this research recommendations are made across four landscapes including clinical practice, end of life care education, end of life care simulation, and research on end of life care simulation. Firstly, it is recommended that students are supported during their first death experiences in clinical practice through clinical supervision and reflection and that students be prepared for undertaking post mortem care and the possibility of bad death experiences. It is recommended that end of life care education be commenced early in the undergraduate nursing degree and before the first nursing clinical placement. For end of life care simulation, it is recommended that students be given the opportunity to experience a range of roles involving the family and RN. Furthermore, end of life simulation needs to

include all three moments of time across the time continuum (before death, at the time of death, and post mortem) providing a comprehensive and holistic end of life care experience. Additionally, simulation needs to include standardised patients in roles to enhance realism and provide students the opportunity to engage in difficult conversations at the end of life. Finally, it is recommended that simulation include an unfolding scenario approach utilising small group sizes. Recommendations for research include to investigate the best practice for pre-briefing and debriefing of end of life care simulation to ensure psychological safety of students, and research that compares different simulation models of teaching end of life care simulation, for example, comparing unfolding simulation with stand alone cases.

Each and every one of us will at some time in our lives be touched by death in its many forms. Nurses, especially student nurses, our registered nurses of the future, need to be emotionally and conceptually prepared to provide sensitive and quality end of life care. Nurse educators and nursing clinicians play a large role in ensuring nursing students are prepared and supported to provide this care during this important time of life.

To conclude, through narrative inquiry a deep understanding of undergraduate nursing students' experiences with end of life care and end of life care simulation has been gained. This understanding informs nursing educators and nursing clinicians who have the power and the ability to transform experiences for nursing students and, therefore, improve the quality of care for patients and their families at the end of life. Additionally, nursing educators, through the use of end of life care simulation, can improve undergraduate nursing students' preparedness to undertake end of life care in clinical practice. The study reported in this thesis makes an important and original contribution to the scholarly literature on simulation at the end of life and is the first narrative inquiry study that has provided comprehensive insight into undergraduate nursing students' stories of experience with end of life care and end of life care simulation. This study indicates that end of life care simulation is a strong pedagogical and transformative approach to help prepare undergraduate nursing students to provide quality end of life care in clinical practice.

Chapter One: Introduction

1.1 Introduction

We live our lives through stories. For me, this thesis holds many stories, stories of love and loss, and of birth and death. My construction of stories of experience with end of life care and end of life care simulation has revealed reflexive relationships between living, telling, reliving and retelling these life stories (Clandinin & Connelly, 2000; Huber, Caine, Huber, & Steeves, 2013). In reliving and retelling these stories, I found a deep connection with my research participants as I endeavoured to truthfully tell their stories of experience as I lived alongside them, sharing in their experiences vicariously.

In my thesis, I aim to give voice to undergraduate nursing students' experiences with end of life care (personal and professional) and end of life care simulation. I use the first person to convey a sense of social significance (Clandinin & Connelly, 2000) and to provide a "unique stamp" of the inquirer's perspective (Clandinin & Connelly, 2000, p. 151). Presenting texts written in the first person is not new to narrative inquiry (Bresler, 2006; Connelly & Clandinin, 1990, 1994; Spector-Mersel, 2010) and emphasises the researcher's narrative actions (Chase, 2005). By using the subjective 'I', I aim to be transparent about my presence within my research and my research relationships (Etherington, 2007).

Throughout my thesis I hope to share with the reader rich stories of experience of participants, however, the depth of experience and stories at times may be limited because of the high numbers of research participants (n=18). In narrative inquiry, small numbers of participants are often followed for unfolding and extended periods of time (Clandinin, Caine, Lessard, & Huber, 2016). This was however, not a luxury I had for my research. Participants in my research were 3rd year nursing students who I only had contact with over 2 points in time, the first during the simulation experience, and the second, during the post simulation interview which only spanned several months. It was not within the scope of my research to follow students for a number of years and across multiple interactions as seen in many narrative inquiry studies (Clandinin, 2013; Clandinin et al., 2016). This inability to revisit participants for extended periods of time may have in some instances resulted in a lack of richness in participant stories. In retelling and reliving participants' stories, I am at times left wondering about my participants' ongoing lives in living amidst other end of life care experiences.

Chapter One of my thesis begins with providing a background to the study to set the scene of the significance this research has for end of life care education and promoting quality end of life care experiences for patients, their families and for nurses. Because my experiences

are intermingled with students' experiences, I also share my own end of life care stories of experience and my narrative beginnings, locating myself within this research amidst these shared landscapes, taking an ontological and epistemological position alongside the participants.

Following this, I uncover my research puzzle (and research aims) that I have set out to unpack and piece together. The use of the term 'research puzzle' instead of 'research question' closely aligns with the work of Clandinin and is what sets narrative inquiry apart from other methodologies (Clandinin, 2013). Using the term research puzzle gives a sense of searching and a sense of wonder surrounding the research (Clandinin, 2013; Estefan, Caine, & Clandinin, 2016). Together with the concept of the research puzzle, I use the metaphor of a patchwork quilt to capture the phenomena of experiences of the participants.

Using the metaphor of a quilt made up of different coloured blocks representing each student, the threads revealed from students' multilayered stories (Estefan et al., 2016) of experience will be interwoven and pulled together, joining each quilt block to form a final, unique, colourful patchwork quilt. The use of the quilt metaphor is meaningful to me because my own story involves working with fabrics and threads to create personalised patchwork quilts. In the way that my patchwork quilt is formed, so too, a research puzzle is created, explored and pieced together.

At the end of Chapter One, I present an outline of the structure of my thesis.

1.2 Background to the Study

Nurses are the primary providers of end of life care and being with someone who is dying is not only a privilege but an essential part of nursing practice. However, international and Australian research undeniably indicates that undergraduate nursing students are largely unprepared to provide competent and quality end of life care and provide a caring presence at this important time of life (Brajtman, Fothergill-Bourbonnais, Casey, Alain, & Fiset, 2007; Fabro, Schaffer, & Scharon, 2014; Johnson, Chang, & O'Brien, 2009; Ladd, Grimley, Hickman, & Touhy, 2013; Mallory & Allen, 2006; Moreland, Lemieux, & Myers, 2012; Peterson, Johnson, Scherr, & Halvorsen, 2013; Ramjan, Costa, Hickman, Kearns, & Phillips, 2010; Salum et al., 2017; Schlairet, 2009). Providing end of life care is a challenging and anxiety-provoking prospect for many undergraduate nursing students (Leighton & Dubas, 2009). A lack of experience and knowledge regarding communicating with patients and families at the end of life is a key concern for students (Cooper & Barnett, 2005; Georges & Gryndonck, 2002; Peterson et al., 2010a, 2010b; White, Coyne, & Patel, 2002).

This lack of preparedness of undergraduate nursing students in dealing with end of life care is a significant issue. Internationally and nationally, various consortiums have sought to address this issue. In Australia, the “Palliative Care Curriculum for Undergraduates” (PCC4U, 2018), in the USA, the “End of Life Nursing Education Consortium” (ELNEC, 2019), in Canada the “Canadian Hospice Palliative Care Association” (CHPCA, 2019), and in the United Kingdom and Europe the “European Association for Palliative Care” (EAPC, 2019) have all developed competencies and guidelines with the aim of adequately preparing nursing students to provide competent and compassionate end of life care.

It is widely acknowledged that the most valuable learning experiences are obtained within the experiential learning environment of clinical practice settings (Baillie & Curzio, 2009; Garrino, Contratto, Massariello, & Dimonte, 2017; Reid-Searl, Happell, Veith, & Eaton, 2012). However, challenges in nursing education continue due to the limited availability of clinical placements for students (Sarabia-Cobo, Alconero-Camarero, Lavin-Alconero, & Ibanez-Rementera, 2016; Smith et al., 2018; Waldner & Olson, 2007). In response to the limited access to clinical placements, nursing educators and faculty are increasingly utilising various experiential and innovative methods such as simulation in a number of clinical scenarios (Hjelmfors, Stromberg, Karlsson, Olsson, & Jaarsma, 2016; Sarabia-Cobo et al., 2016). Simulation can give students the opportunity to develop and refine technical and non-technical skills (Jansen, Johnson, Larson, Berry, & Brenner, 2009) including clinical reasoning skills (Arthur, Kable, & Levett-Jones, 2011; Lapkin, Fernandez, Levett-Jones, & Bellchambers, 2010a).

Whilst there is an abundance of research that investigates the effect of using simulation in nursing education (Comer, 2005; Feingold, Calaluca, & Kallen, 2004; Larew, Lessans, Spunt, Foster, & Covington, 2006), this research has been mainly limited to the teaching and assessment of procedural skills. Smith-Stoner (2009a) describes the potential benefits of using simulation in addressing the issues related to death and dying and end of life care. It has been suggested that patient simulators can “provide an effective bridge between the unknown of caring for a dying person and developing the skills necessary to facilitate a meaningful death experience for patients and families” (Smith-Stoner, 2009a, p. 115).

Introducing simulated end of life experiences has the potential to provide interactive and effective instruction in end of life care that can otherwise be absent in limited clinical placement experiences. There is an increasing amount of research on end of life care simulation that suggests the use of simulation for end of life care has the potential to enhance nursing students’ experiences with end of life care (Bloomfield, O’Neill, & Gillett, 2015; Kirkpatrick, Cantrell, & Smeltzer, 2017; Kunkel, Kopp, & Hanson, 2016; Lewis, Reid, McLernon, Ingham, & Traynor 2016; Venkatasalu, Kelleher, & Shao, 2015). However, there

are several gaps in this research, especially in relation to undergraduate nursing students' ontological stories of experiences with end of life care simulation.

1.3 Narrative Beginnings: My Ontology of Experience

In this study I take an ontological and epistemological position within my research. Firstly, my ontology of experience explores the essence of what it was like for me to experience death for the first time as a young student nurse. Epistemologically, I explore beyond my own ontology of experience to seek to understand and theorise the experiences of the research participants.

My ontology involves stories of inadequate first death experiences, which have paved the path for my nursing career and led to this doctoral research journey. Amidst these stories are also stories of grief and loss as I experienced the end of life journey of several people dear to me during my doctoral studies. At first, death knocked gently on my door, taking hold of my father's hand, and not long after, taking hold of my mother's hand, easing me into the grips of truly experiencing grief for the first time. Still reeling from the death of both parents, death would soon re-enter my life, this time thrusting through my front door with little warning with the death of my close friend and colleague at the age of 34 from breast cancer. Not long after without warning death ploughed through my life with the sudden traumatic death of my 16-year-old nephew. Death not finished with me, soon reappeared, sneaking through the back door and taking away another dear friend to cancer. At this stage it seems that finally death has wandered away, if only for a short time.

Although during the latter stages of my doctoral research journey, death became a constant and unwelcome visitor, the story that began this journey, my first death experience as a student nurse, is the one that has led me to where I am today in my doctoral and professional life's journey.

I still remember my own first death experience as if it was yesterday, at the age of 18 as a junior student nurse on my first day of clinical practice in a mixed male/female medical ward. This experience left me feeling inadequate and ill prepared for the strong emotional feelings that followed caring for Jack (pseudonym) at the end of his life. I remember entering Jack's room and feeling the sense of loneliness and isolation. I recall thinking about how frightened he must have felt, this fear evident in his eyes and on his face. I remember feeling a deep sense of insecurity within my nursing role, struggling to provide a caring presence for Jack when I felt so inadequate within my role due to my lack of experience and education. Jack had an above knee amputation several years prior to his illness and death, adding to my sense of sorrow for this person who died not only alone but not whole, increasing my sense

of helplessness and powerlessness. I also felt ill prepared in how to communicate and support this man during his dying phase. None of my limited nursing education had any component of end of life care and none of the nursing staff on this ward had even considered my lack of preparation or experience in managing these situations or how this might affect me as a new nursing student. Attending to Jack's disembodied post mortem care with the registered nurse (RN) comprised of washing the body, placing Jack in a white shroud and applying paper name tags before finally placing him in a white body bag for transfer to the hospital morgue. Following this, I felt numb for the rest of the day, not really knowing why. The initial lack of support from other nursing staff left me bewildered and feeling lost.

One of the most memorable things following this experience was an overwhelming feeling of lack of preparedness for undertaking this care. Like many new nurses this was my very first experience with seeing and touching a deceased person. I also had a lack of understanding of the importance of this care for the deceased person and their family. Following this experience there was little opportunity to debrief and reflect on my thoughts and feelings. Other nurses were aware this was my first experience, but they had little time and motivation to provide me with the support I needed. In the busy ward environment the expectation was to just cope with things and move on with the tasks required to get through the shift.

This experience has had a profound effect on me throughout my nursing career and has been one of the overarching reasons and impetus for me to eventually move into the area of palliative care nursing and finally, into undergraduate nursing education and undertaking this research. My motivation was to support and prepare nursing students with their end of life care experiences and to promote passion, knowledge and sensitive, dignified end of life care of patients and their families.

Reflecting upon my own experiences, it is evident that unfortunately, these issues are still faced by undergraduate nursing students today. Recently, one of the students I was teaching before my research journey began, told me of their experience during a residential aged care clinical placement that involved a story similar to mine. This student nurse described a very traumatic event that involved post mortem care without any prior preparation. Undertaking this care with another student, they were left 'floundering' and feeling inadequate undertaking this patient's post mortem care without any support from other experienced nursing staff. This student felt that they could not ask for any help or support. There was also no follow-up support or debriefing following this incident, leaving these students to cope alone and support each other using the limited skills they had. This incident highlights the vulnerable nature of students placed in this and similar situations. As evidenced in this story, the practice of non-preparation and non-support that was part of my first death experience, thirty years previously, is still a common practice today. This lack of preparedness of undergraduate nursing students for end of life care needs to be addressed not only by undergraduate nursing

programs but by all nursing staff involved in end of life care. This is especially necessary for mentors who support and meet the clinical needs of undergraduate nursing students.

1.4 My Research Puzzle

To piece together my quilt and unpack my research puzzle of “**What is the undergraduate nursing students’ experience with end of life care and end of life care simulation?**”, I focused on three research aims, which were to:

- 1) Explore the end of life experiences, personal and professional, of undergraduate nursing students prior to end of life care simulation;
- 2) Explore experiences of undergraduate nursing students with end of life care simulation; and
- 3) Investigate the impact of end of life care experiences and end of life care simulation on the undergraduate nursing student.

It is through these research aims that I unpack my research puzzle and piece together the fabric of my quilt.

1.5 The Significance of the Study

Nurses are at the forefront in caring for patients in any clinical setting and are, therefore, the most likely of all health professionals to be caring for patients at the end stage of their lives. Nurses also make the greatest contribution to the quality of life of these patients and their families. With the number of people aged 60 and over expected to increase worldwide from 962 million to 1.4 billion in 2030, and to 2.1 billion by 2050 (United Nations, 2018), internationally, nurses will increasingly be required to provide quality care at the end of life. Correlating with this is an expected increase from 15% of the Australian population aged over 65 years in 2016 to 22% of the population by 2056 (Australian Institute of Health and Welfare [AIHW], 2018), Australian nurses, too, will increasingly be required to provide end of life care to patients across all healthcare settings as a core component of their practice (Cairns & Yates, 2003). However, nursing curricula, nationally and internationally, has not adequately equipped nurses with skills required to effectively care for these patients at the end of life (Johnson et al., 2009; Lloyd-Williams & Field, 2002). Challenges in nursing education include a lack of clinical placements creating fewer clinical learning opportunities (Bland, Topping, & Wood, 2011; Ricketts, 2011), shortages of clinical facilitators (Schlairet & Pollock, 2009), limited education on end of life care (Carmack & Kemery, 2017; Cerit, 2017; Jors et al., 2016; van der Wath & du Toit, 2015), and an already overloaded undergraduate nursing curricula (Ramjan et al., 2010). With these limitations and challenges in mind, it is important that

nursing educators seek innovative and experiential ways of providing opportunities for nursing students to practise end of life care within safe and supportive environments.

In unpacking this research puzzle, the findings of this study build knowledge on the experiences of undergraduate nursing students with simulated end of life care. Furthermore, critical thinking skills that students utilise in dealing with end of life situations are better understood. More importantly, the study identifies emotions and feelings that student's experience in such intense and emotionally charged situations and informs nursing academics and clinicians on how they can facilitate and support future nursing students. The study also provides evidence on how end of life care simulation can be used as a teaching strategy to facilitate confidence and competence in end of life care for undergraduate nursing students. By promoting confidence and competence in end of life care this may, in turn, be translated into improved end of life care for patients, their families and their carers in clinical practice.

1.6 Organisation of the Thesis

This thesis is presented in five chapters. Chapter One, has provided an introduction to the research study.

Chapter Two of this thesis presents a critical review of the literature on end of life education and end of life care simulation and provides a discussion on key themes and issues identified using simulation to teach end of life care in undergraduate nursing degree courses. The findings of the literature review provide recommendations and justifications for the research and the methodology used in my research.

Chapter Three discusses the methodology used in unpacking the research puzzle and piecing together my quilt. In this chapter, a justification is provided for the research design and methodological approach used. Ethical considerations, participant recruitment, collection and analysis of field texts, trustworthiness of the research and researcher reflexivity are also discussed. Finally, I become intertwined with the research participants in relational ways, as I aim to address the relational ontological and epistemological commitments of narrative inquiry.

In Chapter Four, the students' ontological stories of experience with end of life care and end of life care simulation are presented as storied threads of experience. In this chapter, I continue to take an ontological and epistemological stance to fulfil the commitments of narrative inquiry and the ongoing attentiveness to the storied experiences of who I am and

who I am becoming within this research (Dubnewick, Clandinin, Lessard, & McHugh, 2018), by interweaving my own stories of experience.

In the final chapter of my thesis, Chapter Five, I provide an in-depth discussion on the threads identified from Chapter Four and provide a critical discussion on the singularities and commonalities of interlacing threads based on a critical analysis and synthesis with the available literature. Strengths and limitations of the study are discussed, and implications and recommendations for education, practice and research are proposed. Finally, in conclusion to the thesis, I include my own reflections and interpretations of the research findings.

1.7 Conclusion

In summary, this chapter has provided the foundations for my research. The chapter has introduced the research topic, provided a background to the study, and explored my own ontological experience with end of life care through my narrative beginnings, situating myself within the context of my research. Following this, the research puzzle and aims of the study, and the importance of unpacking this research puzzle and the significance of this research have been discussed. Finally, an outline of each of the chapters has been provided. The following chapter will present a critical review of the available literature on end of life care education and end of life care simulation.

Chapter Two: Positioning an Inquiry Within the Scholarly Literature

2.1 Introduction

The purpose of this chapter is to present the findings of a comprehensive literature review on the research undertaken to date on end of life care education and simulation. Firstly, I provide the work I have already done as part of this literature review. These publications provide a critical review on the available literature on end of life care education (Gillan, van der Riet, & Jeong, 2014a; Appendix A) and end of life care simulation (Gillan, Jeong, & van der Riet, 2014b; Appendix B).

Due to the time lapse (I was enrolled for nine years), an updated literature search (2013–2018) was conducted. In this chapter, I provide an outline of this updated search strategy and an outline of the findings of recent literature available on end of life care simulation. Findings of the papers identified in the updated literature search will be discussed and synthesised in Chapter Five. Finally, in this chapter, I discuss the implications and recommendations for further research, which has justified my research topic and informed my research design.

2.1.1 Rationale for the Two Literature Review Papers

The first of these publications provides a critical review of the literature on end of life care education (Gillan et al., 2014a). This first publication revealed insights into the landscapes of end of life care education, giving a historical and contemporary perspective on how end of life is treated in nursing curricula internationally and within the Australian tertiary environment. This literature review includes educational strategies used before the emergence of end of life care simulation within the literature.

The second publication provides a critical review of the literature on end of life care simulation (Gillan et al., 2014b) and revealed a significant turning point in end of life care education. Despite an increasing presence of end of life care education in undergraduate nursing programs, several issues identified in the first literature review remain unresolved resulting in nursing students feeling a lack of preparedness to undertake end of life care in the clinical environment (Gillan et al., 2014a). As a result, nursing educators sought more innovative and interactive methods of teaching in an attempt to help prepare students to provide quality end of life care in the clinical setting. This publication introduces the emergence of end of life care simulation within the scholarly literature, and provides a critical insight into how this emerging

teaching method has evolved from its inception in 2009 until the time of this publication in 2014. These two publications are included in the following sections as word documents.

In Section 2.2, Publication 1:

Gillan, P. C., van der Riet. P. J., & Jeong, S. (2014a). End of life care education past and present: A review of the literature. *Nurse Education Today*, 34(3), 331–342. doi:10.1016/j.nedt.2013.06.009

2.2 End of Life Care Education, Past and Present: A Review of the Literature

Key Words: End of life care education, undergraduate nursing students

ABSTRACT

Background: Research on end of life care education suggests that undergraduate nursing students are largely unprepared to provide end of life care to dying patients and their families. Although there have been attempts to address the issue of lack of preparedness, little is known on how to improve this. **Literature Review Aims:** To examine how end of life care education has been delivered to undergraduate nursing students and to critically discuss the research on modes of delivery and teaching strategies. **Review Methods:** An extensive literature search on end of life care education in the undergraduate nursing curriculum was conducted in CINAHL, Mosby's Index, Cochrane Database, Scopus, Eric via Proquest, and Medline. 18 research papers published between 1984 and 2012 that met the selection criteria are included in the review. **Findings:** Findings of these 18 articles are reported under two main themes; Modes of End of Life Education Delivery and End of Life Care Education Initiatives. **Conclusion:** This review highlights issues with end of life care education and suggests that end of life care simulation is an innovative strategy that may help to prepare undergraduate nursing students to provide quality end of life care.

INTRODUCTION

Research suggests that nursing students have anxieties about and difficulty dealing with death and dying (Mallory, 2003). Students are not ready to cope with issues related to death and dying, feel unprepared to care for these patients (Johnson et al., 2009) and view caring for dying people and their families as one of the most distressing and potentially unpleasant tasks that a nurse can do (Allchin, 2006). Caring for dying patients also ranks highly on nurses' experience of stress (Gibbons et al., 2010) and is reported as the second most common source of nursing stress for Australian nurses (Johnson et al., 2009). These findings indicate that undergraduate nursing programs are not adequately preparing nursing students to care for people at the end of life (Mallory, 2003; Allchin, 2006; Johnson et al., 2009; Gillan

et al., 2013). This lack of education is reflected in the level and quality of end of life care provided to patients (Mallory, 2003).

BACKGROUND

Evidence suggests that end of life care education is an important factor in preparing nursing students for end of life care, and that this may be the most significant factor affecting nursing students' attitudes toward care of the dying (Frommelt, 1991). It is recommended that student's undergraduate training should include a significant amount of both didactic and clinical end of life content (Barrere et al., 2008; Mallory, 2003).

Despite of an increasing amount of death education in undergraduate nursing programs seen today (Barrere et al., 2008), there are many issues identified in the literature with end of life care education resulting in nursing students reporting feelings of lack of preparedness (Mallory, 2003; Dickinson et al., 2008; Johnson et al., 2009; Ramjan et al., 2010).

Research has revealed that there is little content on end of life care in undergraduate nursing textbooks. For example, Ferrell et al. (1999a); Ferrell et al. (1999b), Ferrell et al. (2000a); and Ferrell et al. (2000b) conducted an analysis of 50 nursing textbooks. These studies revealed minimal content on issues related to end of life care with only 2% of texts addressing an end of life topic (Ferrell et al., 2000b).

Furthermore, another major issue identified in the literature is lack of content on end of life care in the undergraduate nursing curricula. Education of death and dying continues to have a minimal and inconsistent presence in most undergraduate nursing curricula and training is neither adequate nor appropriate (Mooney, 2005; Barrere et al., 2008; Johnson et al., 2009). Despite attempts to adequately prepare students for end of life care many nursing programs do not have a dedicated or elective course on palliative or end of life care (Hurtig and Stewin, 1990; Barrere et al., 2008), instead integrating content throughout other courses in nursing (Hurtig and Stewin, 1990). In the United States of America, only 3% of 311 nursing programs surveyed had dedicated courses on end of life content in their curricula (Wells et al., 2003) and an average of less than 14 hours was spent on end of life issues (Dickinson et al., 2008). In the United Kingdom a mean of between 7.8 and 12.2 hours was spent on teaching about death and dying (Lloyd-Williams and Field, 2002). In Australia, of the 26 undergraduate nursing programs surveyed, only 8% (n=2) allocated > 20hours, while 48% (n=12) allocated 5-10 hours of content on death and dying (Johnson et al., 2009). The authors recommended that urgent attention be given to embedding theoretical content in sufficient depth combined with teaching strategies to promote critical reflection in end of life care.

The literature highlights that not only is the amount of time dedicated to the content an important factor but also that the modes of delivery and teaching strategies used are also of importance.

AIMS

The aims of literature review were to 1) examine how end of life care education has been delivered to undergraduate nursing students over the last 30 years, and 2) critically discuss the research on modes of delivery and teaching strategies used in end of life care education in undergraduate nursing education.

This paper presents the findings of the first of a two part series exploring end of life care education in undergraduate nursing programs. Past and present methods of providing end of life care education in the undergraduate nursing curriculum will be discussed providing a uniquely Australian, as well as an international perspective. Part two will introduce the emergence of end of life care simulation and provide an extensive review of current evidence on end of life care simulation.

REVIEW METHODS

A search of published literature between 1984 to 2012 on end of life care education was conducted on Cumulated Index to Nursing Allied Health Literature (CINAHL), Mosby’s Index, Cochrane Database, Scopus, Eric via Proquest, and Medline. The search terms used are cited in Table 2.1.

Search terms used in initial search strategy

Table 2.1: Search terms used in initial search strategy.

Search Terms:	“AND”	Search Term limiters
Undergraduate Nursing Students/ Nursing Degree Students/ Bachelor Degree Nursing Students/Baccalaureate Degree Nursing Students	End of life care/Palliative care/Terminal care/ Hospice care//Bereavement/ /death/death and stress/ Death education/curricula/curriculum/undergraduate nursing programs	-not end of life care -not undergraduate nursing students -not education -conference abstracts -letters -editorials
Total Results:	61	Limiters: 144

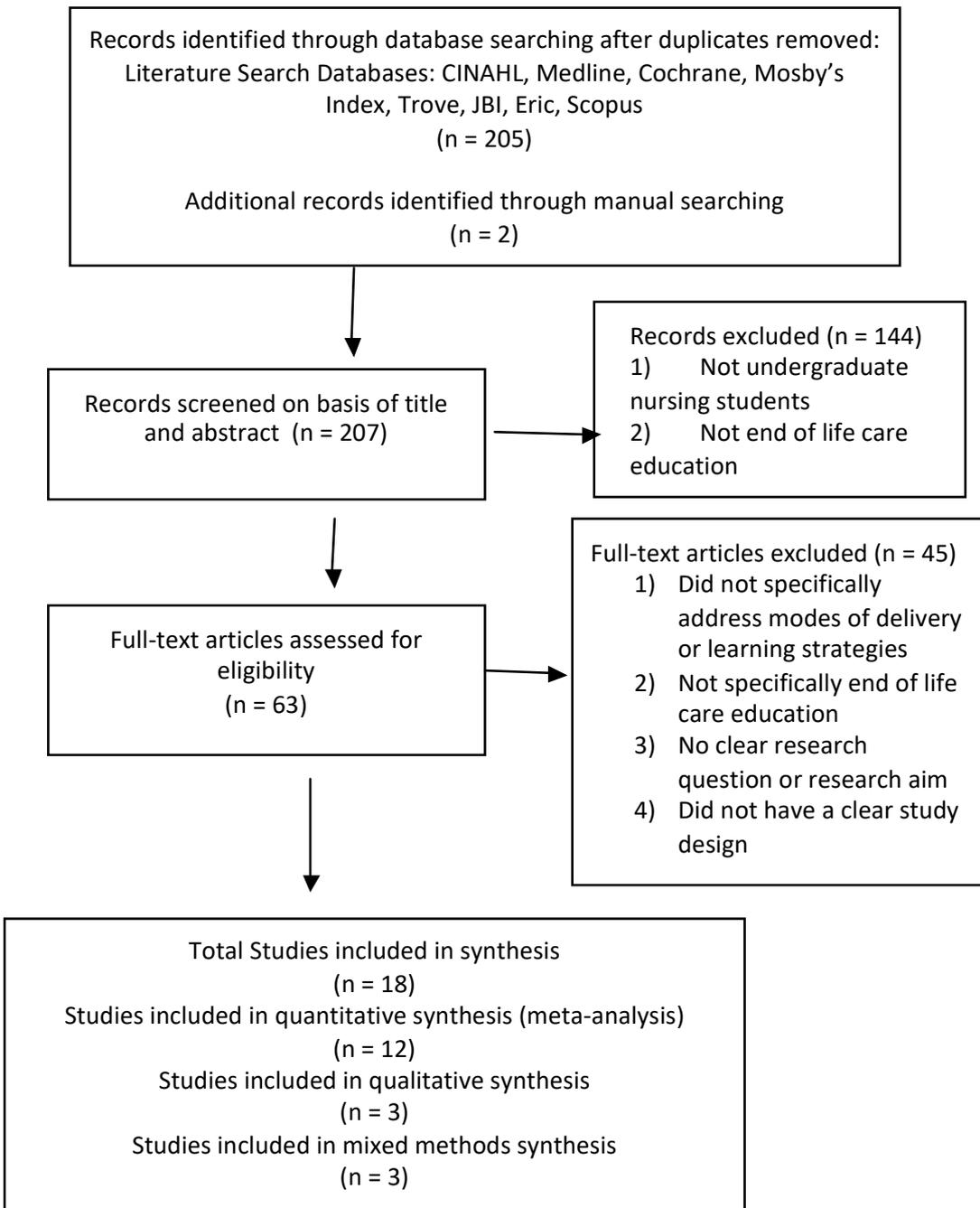
The preliminary literature search located 205 articles. These articles were reviewed for content specifically related to the inclusion criteria of: ‘end of life care education’; and

'undergraduate nursing students'. A total of 61 articles met the inclusion criteria. A further 2 articles were identified from reference lists of the identified papers (n=63).

Due to the high numbers of identified literature on this topic, the following criteria were used to cull high quality research studies: research that 1) specifically assesses modes of delivery and learning strategies on end of life education for undergraduate nursing students; 2) have a clear research question or research aim; 4) have an identifiable study design. 18 research studies are included in the review. Table 2.2 provides a decision flow diagram.

Research papers were analysed using thematic analysis by the primary author. Two key themes were identified; Modes of end of life education delivery, including the subthemes of active and experiential learning; and education initiatives. Identified themes and subthemes were confirmed by the other authors of the review. This process of peer review ensured rigour and trustworthiness of thematic analysis.

Table 2.2: PRISMA Flow Diagram



FINDINGS AND DISCUSSION

Modes of end of life education delivery

End of life education in undergraduate nursing curricula has traditionally been delivered via theoretical methods in the form of classroom lectures (Hurtig and Stewin, 1990) and small group discussion (Johansson and Lally, 1991; Jo et al., 2009) and these continue to be the primary modes of teaching. However, traditional lectures and other didactic modes of delivery do not provide the opportunity for students to examine their personal reactions to their own experiences and to dying patients (Mok et al., 2002). More promising are the various modes of end of life care education that have recently emerged to promote active and experiential learning. These include hospice visits (Kwekkeboom et al., 2005; Kwekkeboom et al., 2006), intensive death and dying education programs, and the use of audio-visual aids (Caty and Tamlyn, 1984; Hurtig and Stewin, 1990; Johansson and Lally, 1991; Jo et al., 2009; Dobbins 2011). Table 3 depicts a summary of research studies on modes of delivery.

Active learning is a process that involves strategies or instructional methods that require active student engagement that promotes a greater depth of learning (Sand-Jecklin, 2007). The strategies and instructional methods used to promote students' engagement in thinking about their roles in end of life care include 1) listening to audio recordings (Johansson and Lally, 1991); 2) viewing selected films on death and dying (Caty and Tamlyn, 1984; Johansson and Lally, 1991; Dobbins, 2011); 3) use of art (Jo et al., 2009); and 4) discussions, quizzes and tasks (Lockhard, 1989; Jo et al., 2009). While it is acknowledged that these quantitative studies using experimental or quasi-experimental study designs made an innovative attempt at promoting active learning there are a number of issues identified in designing and implementing teaching strategies and methods.

Firstly, the instructional method should be purposefully selected and readily available. In the use of film, Dobbins (2011) recommends that film clips should be chosen to evoke desired emotions such as empathy and compassion. Secondly, the instructional method is most effective if accompanied by supplementary strategies such as group discussion and reflection. For example, Dobbins (2011) found the use of film to be more effective when followed by reflective learning activities. Thirdly, it is not only the quality of teaching method implemented but also other variable factors, such as the level of the student (junior level or senior level) to be considered for the teaching strategy to be effective. The death education program implemented by Johansson and Lally (1991), using audio and video clips was effective in decreasing the death anxiety of some senior students but increased the death anxiety of some of the junior students. Finally, Jo et al. (2009) incorporated multiple active learning strategies delivered over a 16 week death education program. They found that end of life care education positively affected students' care performance. Active learning

strategies were effective in clarifying the significance of the suffering experience positively affecting nurses' attitudes towards death. Although, this study involved a largely homogenous and small sample, the findings are important in adding to the limited available literature on such programs.

In summary, active learning processes provide an atmosphere that fosters discussion and acquisition of knowledge (Jo et al., 2009). However, for it to be effective, the issues discussed above need to be considered.

Experiential learning is described as learning that encourages students to reflect on and learn from human experience (Kwekkeboom et al., 2006). The strategies and instructional methods used to promote meaningful reflection and experience include 1) clinical case studies (Wong et al., 2001; Mok et al., 2002); 2) volunteer hospice companion programs (Kwekkeboom et al 2005; Kwekkeboom et al 2006); and 3) palliative care educational component/death education program (Mallory, 2003; Hurtig and Stewin, 1990; Liu et al., 2011; Mooney, 2005). These studies demonstrate several innovative methods that promote experiential learning, however, there are some issues identified in the design and implementation of these teaching strategies and methods.

Problem Based Learning (PBL) focuses on students being confronted with 'problems' to stimulate learning and discussion. Wong et al. (2001) and Mok et al. (2002) used PBL as an experiential learning strategy to enhance the attitudes, knowledge and skills of nurses caring for dying patients. It is notable that these are qualitative studies on modes of delivery of end of life care education while the majority of the studies are quantitative. In these studies, senior students' journals were analysed using a case analysis approach. Students perceived that they acquired knowledge and communication skills through PBL. However, there were no systematic observations and evaluation of the students' communication skills in the study to support the self-report of knowledge and skill acquisition. Although Wong et al. (2001) claimed that the use of PBL was an effective experiential learning strategy that encouraged critical thinking, creativity in learning, personal growth, team work, and research skills, due to study limitations these results require careful consideration.

Volunteer palliative care companion programs designed to provide undergraduate nursing students with experiential learning experiences are an innovative teaching and learning strategy for palliative care education. Two such programs by Kwekkeboom, et al. (2005) and Kwekkeboom, et al. (2006) demonstrate some promising results. Both studies used small sample sizes of 2nd and 3rd year undergraduate nursing students (34 participants and 52 participants respectively) and employed a quasi-experimental controlled pre-test and post-test study design employing three data collection instruments. Results indicated that students' knowledge of and attitudes toward palliative care improved and their concerns

about caring for dying patients significantly decreased. However, the small sample size suggests the improvement was not statistically significant. Despite the small sample size this teaching strategy has the ability to provide students with experiential learning experiences with end of life care. Further rigorous evaluation beyond course evaluation needs to be undertaken to investigate if the improvement will be clinically significant before this strategy can be considered as an effective teaching and learning strategy.

There are a number of quantitative studies that sought to assess the effects of various experiential educational programs on end of life care. These studies include experimental studies (Hurtig and Stewin, 1990; Hutchison and Scherman, 1992), quasi-experimental studies (Kwekkeboom et al., 2005; Mallory 2003; Mooney 2005), and a mixed methods study (Kwekkeboom et al., 2006). The findings from these studies provide mixed results. In an early study, Hurtig and Stewin (1990) used an experimental study with random assignment into one of three experimental groups (didactic group n=27, experiential group n=23, control group n=26) to investigate the effect of a death education program and personal experience with death on the attitudes of nursing students. Two way analysis of Confrontation-Integration of Death Scale (CIDS) scores indicated that neither the death education treatments nor personal experience independently produced a significant variation in death confrontation or death integration scores. Hutchison and Scherman (1992) compared the effectiveness of didactic teaching with experiential death and dying education on the reduction of death anxiety measured by the Templer Death Anxiety Scale (DAS) and the Thematic Apperception Test (TAT) in a cohort of female nursing students (n=74 1st year nursing students, didactic group n=39, experiential group n=35) from three nursing schools in the USA. This study found that education, regardless of type, did reduce self-reported death anxiety, although the change was small.

More recently, Mallory (2003) used a quasi-experimental, longitudinal design with a pretest, intervention (didactic and clinical experiences), and double post-test format to examine the impact of a palliative care educational component on the attitudes toward care of the dying (measured by the Frommelt Attitudes Towards Care of the Dying Scale [FATCOD]) in junior undergraduate nursing students from 2 nursing schools in the USA (Pretest n=104; Post-test n=95; Post-post-test n=36). This study concluded that nursing students' attitudes toward caring for dying patients improved after an experiential educational component in palliative care. In the only Australian study on experiential learning in end of life care, Mooney (2005) conducted a quasi-experimental non-equivalent control group design and used a didactic/experiential approach to measure the effectiveness of a death education program in reducing death anxiety in undergraduate nursing students (experimental group n=97, control group n=122 pre and post-test matched data sets). Findings from this study further support a death education program as effective in reducing death anxiety.

In summary, experiential learning strategies provide students with opportunities to integrate knowledge and experience and promote meaningful learning experiences through reflection. An important finding is that no previous personal experience may be a significant variable (Hurtig and Stewin, 1990). There was a significant relationship between previous death education and attitudes towards care of the dying (Mallory, 2003). The lessons learned from these studies include that end of life education should involve a combination of both clinical experiences and didactic approaches for a comprehensive end of life care learning experience. It also suggests that experiential programs can be effective in reducing death anxiety, especially when the program allows individuals to examine and resolve attitudes and beliefs over time rather than a short intensive program (Mooney, 2005). Despite these lessons, the findings from these studies require careful attention for the following reasons. Firstly, the small sample size reduces statistical significance. Secondly, the reliability and validity of some of the tools used in these studies are not discussed.

End of Life Care Education Initiatives

Recent advances in end of life education by consortia such as the End of Life Nursing Education Consortium (ELNEC) from the US and Palliative Care Curriculum for Undergraduates (PCC4U) in Australia provide a combination of both active and experiential learning methods of teaching (PCC4U, 2005).

ELNEC is an educational program designed to improve end of life care by nurses, funded by the Robert Wood Johnson Foundation (Wallace et al., 2009). *ELNEC* teaching strategies include a range of interactive methods of teaching including group discussion, cumulative loss exercises, case studies, storytelling, testimonials, poetry and pictures. Several researchers' efforts to integrate these methods into their programs are notable. Barrere et al., (2008), Dobbins (2011) and Weissman (2011) used a quasi-experimental study design, while Wallace et al. (2009) used a mixed methods approach to evaluate the impact of *ELNEC* education content on students' attitudes towards caring for dying patients.

Barrere et al. (2008) found a significant change in attitude in students ($n=73$) with no previous death experience ($t=-3.687, p = .000$). A younger age was the most powerful predictor of a change in attitude from pretest to post-test, supporting findings made by Hurtig and Stewin (1990). Dobbins (2011) conducted two separate studies (study 1- intervention group $n=12$, control group $n=25$ and study 2 intervention $n=16$, control $n=22$) and found similar results. The authors found that the *ELNEC* intervention (Communication module) resulted in decreased scores in some of the Death Attitude Profile-Revised (DAP-R) subscales in both intervention groups and an increase in the FATCOD scores reflecting an increase in positive attitudes toward caring for dying patients. Weissman's (2011) pilot study of 17 of 1st year nursing students (intervention group $n=9$, control group $n=8$) evaluated self-efficacy in

communication skills. The control group received standard didactic end of life content (traditional lecture, case study, and group discussions) while the intervention strategies included viewing selected segments of the film '*In the Gloaming*' (Nugiel & Reeve, 1997) and discussion, active listening exercise and role-play activity. Results showed that both approaches were associated with positive changes in self-efficacy (measured by VAS for self efficacy) in communicating with dying patients (not statistically significant), however, the ELNEC curriculum was associated with substantial improvements in attitudes towards care of the dying (measured by FATCOD). Wallace et al. (2009) reports similar results and found that knowledge of end of life care increased throughout the curriculum after integration of ELNEC content into the curriculum.

In response to available evidence that suggests Australian undergraduate programs are not adequately preparing health care professionals for end of life care (Mooney, 2005; Bush, 2012), in 2005 the Australian Government Department of Health and Aging (2011) funded the PCC4U program (PCC4U, 2005). The PCC4U program utilises a range of engaging learning resources including video vignettes and palliative care case studies and scenarios (PCC4U, 2011). Due to the recency of this initiative, there is minimal research available on the effectiveness or use of this in Australian undergraduate nursing programs. The research conducted by Bush (2012) is the only research identified from the available literature.

Bush (2012) used a descriptive/exploratory mixed method in a two phase study. The results are available from phase 1 only which aimed to determine if the completion of a Oncology and Palliative Care elective course (guided by PCC4U outlines and recommendations) on a group of 3rd year undergraduate nursing students aided in the clinical provision of palliative care. A questionnaire was sent to 70 randomly selected students who had recently completed the course with 73% (n=51) response rate. The study found that all participants felt the course influenced their perceived ability to be clinically competent in the facilitation of palliative care and that the course had a positive influence on student's learning of palliative and end of life nursing care. Nevertheless, the study shares similar limitations of other studies already discussed. In addition, potential favourable bias towards palliative care also needs to be considered given that students self-selected themselves for the elective course.

The findings from these studies contribute to the existing body of literature and support the value of integration of end of life care education into undergraduate nursing curricula. The tool (FATCOD) used in three of the studies had strong reliability and validity. However, it is important to note the limitations of the studies. The sample sizes in all five studies mentioned are small which questions statistical significance. Given that the studies were conducted in one institution with small sample size, this limits generalisability of the results. The methodological issues in study design are also important to note; no control group used in

three of the studies, issues with inability to match some pre and post questionnaires in some instances and the data collection instrument of self-reporting nature (Barrere et al., 2008). Furthermore, the reduced control of variable by viewing the same film (Bosanquet & Nichols, 2001) used in the intervention groups (Dobbins, 2011) limits these findings.

Table 2.3: Summary of research studies

Author/s/ Year/ Country	Research Question	Sample	Educational Intervention	Research Design/Methods	Key Findings
Johansson & Lally (1991) USA Active Learning Strategy	1) Would a death education program decrease death anxiety experienced by nursing students? 2) Does the level of the nursing student influence the effectiveness of the death education program in reducing death anxiety?	54 nursing students (22 junior, 32 senior, all female, average age 20.5 years).	1) Film <i>"Gramp: A man Ages and Dies"</i> / discussion 2) Audio <i>"Facing Death with the Patient: An On-Going Contract"</i> / discussion 3) + 4) audio interview (Hospice Director)/discussion; 5) Film <i>"Death"</i> /discussion 6) Audio- <i>"Conversations with a Dying Friend"</i> / discussion.	Quantitative: Randomised experimental group-control group, pretest-posttest design. Instruments: -State Form of the State-Trait Anxiety Inventory (STAI)	Findings: the death education program was effective in decreasing the death anxiety for some seniors, but death anxiety increased for some juniors. -prior clinical experiences with dying patients may be the most important part of a relevant death education program. Limitations: small sample size; all female sample, ethical approval not discussed.
Jo et al. (2009) Korea Active Learning Strategy	No research question. Purpose of research: to examine the effects of end of life care education (using nurses' experience with suffering, attitude toward death, and end of life care performance as measurements).	47 senior nursing students (experimental n=23; control n=24), convenience sample enrolled in "Terminal end of life care course".	16 week EoL Care Education Program: lectures with movies, discussions, quizzes, tasks, attitude toward death through works of art etc.	Quantitative: Quasi-experimental, non-equivalent control group pre-post non-synchronised design. Instruments: -General characteristics -Suffering Experience of the Nurse -Collett-Lester Fear of Death Scale	Findings: the program contributed to the experimental group's positive attitude toward death, and improved end of life care performance. Limitations: small homogenous sample from one nursing school in Korea. No mention of ethics approval.

				-End of life Care Performance	
<p>Caty & Tamlyn (1984) Canada</p> <p>Active Learning Strategy</p>	<p>1) Do nursing students' attitudes toward death and dying change significantly after a death education seminar?</p> <p>2) After completing a death education seminar, do nursing students who have experienced the death of an immediate family member register a more significant attitude change than those who have not?</p> <p>3) After a death education seminar, do nursing students who have nursed dying patients have a more significant attitude change than nursing students who have not?</p>	<p>Experimental group: 33 senior nursing students (83%); Control group: n=22 senior physiotherapy students (88%).</p>	<p>Treatment group: 2 day (16hour) death and dying seminar; Day 1: "Death and Me": loss and grieving, personal experiences with death and dying, spiritual aspects of death and dying, film "<i>Jocelyn</i>"; Day 2: "Death and Nursing": Hospice discussion, communication, group discussion/case study/role play.</p> <p>Control group: no formal required course or planned content on the topic of death and dying.</p>	<p>Quantitative: Quasi-experimental design; Pre-test/Post-test.</p> <p>Instruments: -Questionnaire for Understanding the Dying Person and His Family- pre and post seminar. -Written exam questions, verbal evaluation and measurement of attitudinal change.</p>	<p>Findings: Statistically significant difference in mean scores between pretest and post-post-test (14 months) in the experimental group supports improved attitudes in nursing students. -Statistically significant difference in the mean scores between the two groups at post-post-test supports the value of this two day seminar.</p> <p>Limitations: Small sample size from one university, 30% difference in experimental and control group size.</p>
<p>Lockhard (1989) USA</p> <p>Active Learning Strategy</p>	<p>1) Is there a significant difference between the Death Anxiety Scale (DAS) post-test scores of the two groups?</p> <p>2) Is there a significant difference between the DAS post-post-test</p>	<p>74 students (all female) completed post-post-test.</p> <p>50 students at follow-up test after 1year.</p>	<p>Intervention: 7 hour death education program over 2 weeks: classes on grief and loss, lectures on communication, discussions on personal experiences,</p>	<p>Quantitative: study design not clear (experimental design- pretest, post-test, post-post-test).</p> <p>Instruments: Death Anxiety Scale (DAS)</p>	<p>Findings: The death education was effective in reducing the death anxiety level (immediately after, 4 weeks later and 1 year later).</p> <p>Experimental group students with previous nursing experience were less likely to have a positive</p>

	<p>scores of students in both groups?</p> <p>3) Is there a significant difference between the DAS follow-up test scores of students from both groups?</p> <p>4) Is there a significant relationship between pretest DAS scores and the age, death experience, or nursing experience of subjects?</p> <p>5) Is there a significant relationship between the experimental group's change in DAS from pretest to follow-up test, and their age, death experience, or nursing experience?</p> <p>6) Is there a significant relationship between the experimental group's change in DAS from posttest to follow-up test, and their age, death experience or nursing experience?</p>		<p>values clarification exercises, audio-visual aids.</p> <p>Control procedures- not discussed.</p>	<p>(pretest, post-test, post-post-test and follow-up at 1 year).</p>	<p>change in death anxiety level than those with no previous nursing experience.</p> <p>Strength: Random assignment into experimental and control groups.</p> <p>Limitations: Student's level of study not disclosed, no's in control and experimental groups not clear. No mention of ethics approval.</p>
<p>Wong et al. (2001) Hong Kong</p> <p>Experiential Learning Strategy</p>	<p>1) What are the behaviour and attitude of nurses towards death and dying at the beginning of the course?</p>	<p>72 sets of journals of senior students enrolled in the "Applied Psychology course".</p>	<p>PBL involving three case based scenarios with three different problems</p>	<p>Qualitative: Case analysis of participant journals.</p> <p>Data collection: Journals</p>	<p>Three themes were identified:</p> <p>1) Nurses acknowledging their emotions when facing death and dying</p> <p>2) A need for nurses to be better equipped in communication and counselling</p>

	<p>2) What changes does PBL bring about in educating nurses in caring for the dying? 3) What are the particular learning effects that have resulted from different problems?</p>				<p>3) A holistic and family centred approach to care.</p> <p>-PBL helped students deal with death and dying issues in a positive manner and to contemplate the care of the dying from different dimensions.</p> <p>Limitations: No participant characteristics, students from one university in Hong Kong..No mention of ethics approval.</p>
<p>Mok et al. (2002) Hong Kong</p> <p>Experiential Learning Strategy</p>	<p>Purpose of research: to monitor the effectiveness of PBL using case analysis.</p>	<p>96 participants (Bachelor of Science in Nursing-conversion degree)</p>	<p>PBL involving three case based scenarios with four different problems</p>	<p>Qualitative: Case analysis of participant journals.</p> <p>Data collection: Journals</p>	<p>Three themes were identified: 1) Increased self-awareness 2) Positive attitudes towards death 3) Providing culturally sensitive care</p> <p>-the study supports the use of PBL in teaching students about death and dying. -students felt that they acquired knowledge and communication skills.</p> <p>Limitations: No systematic observations of the communication and counselling skills of the nurses; No participant characteristics, study limited one university in Hong Kong.</p>
<p>Hurtig & Stewin (1990) Canada</p>	<p>1) How can nurse educators help students to face death related fears before they come to the</p>	<p>23 experiential group; 27 didactic group; 26 in control group; junior</p>	<p>Didactic group: formal lectures, films and group discussion; Experiential group: death awareness</p>	<p>Quantitative: Experimental study comparing the effect of programmes (didactic,</p>	<p>Findings: an experiential program was more effective than a didactic approach for students without personal death experience to</p>

<p>Experiential Learning Strategy</p>	<p>bedside of the dying patient?</p>	<p>nursing students (no clinical experience). Total =76 participants.</p>	<p>exercises, music, drawing and dyadic encounters between students; Placebo group: simulation game on the aging adult, lecture and discussion.</p>	<p>experiential and placebo). Instruments: -Confrontation-Integration of Death Scale (CIDS) -Evaluation form (open-ended questions).</p>	<p>confront feelings and thoughts concerning death. Limitation: small sample sizes in each of the groups. No participant characteristics. Unclear if variables and covariates were considered and controlled. No mention of ethics approval. Strength: Self-selection was controlled by incorporating the treatment into the required psychology course. Random assignment into 3 different experimental groups.</p>
<p>Kwekkeboom et al. (2005) USA Experiential Learning Strategy</p>	<p>No research question. Aims of program: to provide companionship to patients while providing an experiential learning experience in end of life care.</p>	<p>34 (19 companions; 15 controls)- two semesters.</p>	<p>Experimental group: Volunteer Palliative Care Companion Program: 1) 2 hour orientation (second semester also included 2 hour individual "shadowing" orientation). 2) Companion service-patient visits 3) Optional education-viewing film ("<i>On our Own Terms</i>") video series; hospice support groups and education; newsletters. Control group- not discussed.</p>	<p>Quantitative: Quasi-experimental controlled pre-test-post-test design. Instruments: 1) Demographic questionnaire; 2) Palliative Care Quiz for Nurses; 3) Attitudes About Care at the End of life; 4) Concerns About Caring for Dying Patients</p>	<p>Findings: Knowledge scores for all participants improved- companions scores were significantly higher than controls. -companions reported more positive attitudes, fewer concerns, more confidence and less apprehension in caring for dying patients at the end of semester. Limitations: Small sample size; Self-selection of students.</p>

<p>Kwekkeboom et al. (2006) USA</p> <p>Experiential Learning Strategy</p>	<p>1) Do knowledge, attitude and concern scores of palliative care companion subjects improve significantly after participation in the semester long program? 2) Do knowledge, attitude and concern scores of palliative care companion subjects improve more than those of their student peers not participating in the companion experience? 3) What types of activities do the palliative care companion subjects engage in to facilitate their own learning experiences?</p>	<p>52 (32 companions; 20 controls) nursing students</p>	<p>Experimental group: Volunteer Palliative Care Companion Program with 2 orientation sessions (2 hour orientation and shadowing experience).</p> <p>Control group: completed regular undergraduate nursing program activities.</p>	<p>Mixed methods study: Quasi-experimental controlled pre-test-post-test design, qualitative analysis of journals.</p> <p>Instruments: 1) Demographic questionnaire 2) Palliative Care Quiz for Nurses (PCQN). 3) Attitudes About Care at the End of life; 4) Concerns About Caring for Dying Patients (CAD); 5) Participant journals 6) Post experience information- describe other experiences that may have influenced knowledge and opinions of palliative care.</p>	<p>Findings: The palliative care companion program produced a significant decrease in concerns about caring for dying patients among companion students. -Combining didactic with clinical experiences resulted in the most positive learning.</p> <p>Limitations: -Sample size small with fewer controls than experimentals. -Problems with internal consistency of the PCQN and the measures for attitudes towards Palliative care. -Some students reported other experiences that may have influenced their knowledge and opinions about palliative care. -Students self selected into palliative care companion program.</p>
<p>Liu et al. (2011) Taiwan</p> <p>Experiential Learning Strategy</p>	<p>No Research Question.</p> <p>Research aim: to learn what nursing students experienced during a workshop on life and death issues and how they reacted when they imagined facing their own death.</p>	<p>Sample: n=20, 11 of 1st year, 9 of 2nd year with no experience caring for a dying patient.</p>	<p>Experiential workshop: two 3 hour sessions; Session 1: participants imagined that they had 30 minutes to live-letter writing exercise. Session 2: participants asked to write their own epitaph (90 minute small group discussion).</p>	<p>Qualitative study: Interpretive descriptive design, using thematic analysis.</p> <p>Instruments: -Student's reflective journals, -workshop evaluations, -researchers field notes on observations during</p>	<p>Findings: Students experienced a dying-death-rebirth process. This study provided students with an understanding of reflections on life and death.</p> <p>Major themes identified: 1) Surprise at discovering they had only 30 minutes to live 2) Reluctance to let go- facing death.</p>

				small group discussions.	<p>3) Gratitude for what they had experienced in life. 4) Importance of cherishing the present. 5) Professional commitment- to the nursing profession. 6) Pondering the value of life- students came to understand the meaning of life based on the management of their own lives.</p> <p>Strength: Random assignment into one of two groups.</p> <p>Limitations: small convenience sample of young inexperienced Asian students.</p>
<p>Mallory (2003) USA</p> <p>Experiential Learning Strategy</p>	<p>1) Will there be a significant difference in attitudes toward care of the dying in nursing students who participated in didactic and experiential education and those who did not? 2) Will there be a change in attitudes toward care of the dying in nursing students who participate in palliative care education component? 3) Is there a relationship between nursing students'</p>	<p>Pretest: 104 junior level undergraduate nursing students (Intervention: n=45; Control: n=59). Post-test n=95 (Intervention: n=41; Control: n=54); Post-Post-test: Intervention: n=36. Participants from 2 nursing schools- one used as control and one as intervention</p>	<p>Intervention: Palliative care educational component of didactic and clinical experiences (6 week program).</p> <p>Control group: no treatment.</p> <p>ELNEC content: lectures/ discussion on palliative care, death and dying and pain management, small group discussions and role play in a seminar format, visited gross anatomy cadaver lab, visit to funeral home to</p>	<p>Quantitative: Quasi-experimental, longitudinal design, with pretest, intervention and double post-test (4 weeks post intervention) format.</p> <p>Instruments: -FATCOD.</p>	<p>Findings: A Pearson x2 analysis revealed a significant relationship between previous death education and attitudes toward care of the dying. -A significant positive increase in the attitudes of nursing students toward care of the dying was seen, when compared with the control group.</p> <p>Limitations: -The FATCOD did not identify all previous death experiences and death education and was limited to the attitudes that students were aware of or were willing to report. -Researcher as instructor- may have introduced bias.</p>

	attitudes toward care of the dying and their previous education on death and dying? 4) Will there be a difference in attitudes toward care of the dying in nursing students comparing post-test to post-post-test?		learn about post mortem care, burial options and bereavement services, spent a day at hospice observing hospice nurses, the interdisciplinary team and patients.		-Asking students on pretest about attitudes toward caring for dying patients could affect attitudes on post-test. -Non-random selection. -Participants from small region in the US. -Limited information on the difference in the two groups (the control had more death experiences and education).
Mooney 2005 (Australia) Experiential Learning Strategy	No research question. Aim of research: to examine the effectiveness of a death education program in reducing the death anxiety in Australian undergraduate nursing students.	Experimental group: 115 students completed the pretest scale, n= 97 pre and post matched data sets; Comparison group: 129 students completed the pretest scale, n=122 control group pre and post matched data sets.	Experimental group: single semester death education program (39 hours over 13 weeks) experiential/didactic: weekly 1 hour didactic lecture, and 2 hours of exercises and activities on life and death issues using reflection and journaling. Comparison group: enrolled in a similar program.	Quantitative: Quasi-experimental non-equivalent control group design (Pretest/Post-test). Instruments: -The Lester and Abdel-Khalek version of the revised Collett-Lester Fear of Death Scale.	Findings: the experimental group had a change in overall attitude and fear of death and dying was reduced in regard to death and dying -scores of the control group unexpectedly increased overall. Limitations: a subsample of comparison group attended an anatomy lab prior to completing the instrument for the second time, that may have affected the post-test scores. -No mention of Ethics approval. -limited statistical analysis (mean and standard deviations only). -no mention of level of student Strength: Australian study.
Hutchison & Scherman (1992) USA	Hypothesis: that the experiential group would show greater reduction in death anxiety than the didactic group and that	Sample: 74 female 1 st year nursing students from 3 nursing schools in Oklahoma;	Intervention: Didactic group: 6 hour workshop (lecture, visual aids, and large group discussions stages of grief;	Quantitative: Pretest-post-test analysis of covariance study with two groups. Type of death and dying training and	Findings: Hypothesis was not supported: There were no differential effects of didactic versus experiential training at post-test or follow-up.

Experiential Learning Strategy	the reduction would not be apparent until 8 weeks after training.	Didactic group: 44 students (5 did not complete post-tests), =n 39 students; Experiential group: 39 students (4 did not complete post tests) n=35 students.	Awareness of dying; communication styles; phases of post-bereavement grief; tasks of mourning. Experiential group: 6 hour workshop: exercises exploring personal experiences with death and grief.	occasion used as independent variables. Instruments: -The Templer Death Anxiety Scale (DAS) -Thematic Apperception Test (TAT) -Experiential group post-test (2 days and again 8 weeks after workshop).	The study found that training, regardless of type, reduced self-reported death anxiety on a small scale. Limitations: inability of the investigator to eliminate an experiential component from the didactic training. -No mention of ethics approval
Wallace et al. (2009) USA Education Initiatives	No Research Question. Purpose of project: to report on end of life knowledge and experiences of two groups of nursing students in one small liberal arts university.	Sample: n=111 undergraduate students (61 sophomores, 50 seniors) Questionnaires returned: 38 sophomores and 40 seniors.	Intervention: ELNEC curriculum content. Teaching strategies: discussions on death experiences, asking patients of symptom experiences, ethical issues related to access to end of life care. Opportunity for hospice care and clinical conferences on end of life care issues.	Possibly Mixed Methods- study design is not described. Instruments: -Demographic questionnaire: -Short qualitative questionnaire. -ELNEC 50 item knowledge pretest to determine baseline knowledge of EOL care.	Findings: End of life knowledge increased throughout the curriculum, however there was still limited competence in palliative care. Limitations: limited by small homogenous sample and only one sampling site.
Barrere et al. (2009) Education Initiatives	1-Does the integration of the ELNEC curriculum into a BSN program affect the attitudes of undergraduate nursing students toward care of the dying?	Sample: 103 senior nursing students (61 traditional, 42 accelerated) were invited to participate. Participants: n=73 senior level baccalaureate	Intervention: Integration of the ELNEC curriculum content	Quantitative: Quasi-experimental Pretest/Post-test longitudinal repeated measures design. Instruments: completed at the beginning and end of the professional	Findings: No previous experience with the terminally ill was the strongest predictor of a change in attitude from the beginning to the end of the program. -A younger age was the next strongest predictor of change, those aged 22-25 years had the strongest change in attitude.

	<p>2-Is there a difference between traditional BSN students' and accelerated BSN students' attitudes toward care of the dying before and/or after the integration of the ELNEC curriculum into the programs?</p> <p>3-What factors affect students' change in attitude toward care of the dying after integration of the ELNEC curriculum into a BSN program?</p>	<p>nursing students (39 (53%) traditional; 34 (47%) accelerated) during the students last semester of the senior year participated.</p>		<p>component of their nursing program.</p> <p>1) Demographic questionnaire at the beginning of the study. 2) FATCOD</p>	<p>-ELNEC education program positively affected the attitudes of nursing students toward care of dying patients.</p> <p>Limitations: small convenience sample from one university; no control group; race, culture and ethnicity were not examined; issues with inability to match some pre and post questionnaires; the self reporting nature of the data collection instrument and no opportunity for students to provide additional responses.</p>
<p>Dobbins (2011) USA</p> <p>Active Learning Strategy/ Education Initiatives</p>	<p>No Research Question.</p> <p>Study purpose: to evaluate the impact of an ELNEC elective course on attitudes of students toward death and caring for the dying and to evaluate the effect of an end of life module on the attitudes of a similar group of students.</p>	<p>Sample: Study 1- Experimental group: n=12 (all students enrolled in an elective "Nursing Care at the end of life" course).</p> <p>Control group: n=25 (students enrolled in a required advanced medical/surgical course "Nursing Process 3" with</p>	<p>Experimental: ELNEC Powerpoints, supplemental text, visit to hospice and funeral home, and viewed film <i>Wit</i>.</p> <p>Control: Powerpoint lecture (3 hour ELNEC end of life module, discussion, reference medical-surgical text. (Study 2, control group also required to view film <i>Wit</i>).</p>	<p>Quantitative: A quasi-experimental study design, Prettest/Post-test (14 weeks post).</p> <p>Instruments: -Demographic data -Death Attitude Profile-Revised (DAP-R); -FATCOD.</p>	<p>Findings: students benefitted from both courses.</p> <p>- both groups from both studies, decreased their fearful thoughts and feelings about death and dying, decreased purposeful avoidance of thinking about death, and increased acceptance of death.</p> <p>-All but the students in Study 1 control group demonstrated an increased acceptance of the inevitability of death.</p> <p>-Scores of the FATCOD reflected an improvement in attitude toward caring for the dying in all but the study 1 control group, both intervention groups increased their scores significantly.</p>

		<p>a 3 hour end of life module).</p> <p>Study 2- Experimental group n=16 (all students enrolled in the elective course). -Control group n=22.</p> <p>(All samples from one community college in a semi-rural area of the southeast USA).</p>			<p>Study 2 control group with the end of life module plus viewing Wit, had a significant impact on the fear of death subscale and approached significance on the FATCOD, suggesting a decrease in fear of death and an increase in comfort for caring for dying patients.</p> <p>The results of this study suggested that the ELNEC based elective course significantly decreased aspects of death anxiety and improved student's attitudes towards caring for dying patients. Results also support the use of 'cinemeducation' as a teaching strategy.</p> <p>Limitations: Small sample size from one institution, level of study not clear; Study 2 included the film Wit to the control group- this may limit the results of the intervention for this study.</p>
<p>Weissman (2011) USA</p> <p>Education Initiatives</p>	<p>Research questions: 1) Do students receiving the communication module have improved self-efficacy levels in communication skills compared to the group not receiving the communication module?</p>	<p>Sample: Intervention group: n=9; Control group: n=8; 1st year nursing students attending a private university across multiple</p>	<p>Control group: course module on end of life care, usual didactic lecture powerpoint, case study, group discussion and clinical placement.</p> <p>Intervention group: same course module as well as the ELNEC</p>	<p>Quantitative: Pilot study with a pretest, post-test quasi-experimental design.</p> <p>Instruments: 1) VAS used to measure self-efficacy or confidence. 2) FATCOD Pretest/Post-test</p>	<p>Findings: Both groups reported greater confidence in ability to communicate with a dying patient on the post-test.</p> <p>-Both approaches to teaching were associated with positive changes in self-efficacy in communicating with dying patients, whereas the ELNEC curriculum was associated with substantial improvement in attitudes.</p>

	2) Are there significantly more positive attitudes based on FATCOD in the group receiving the communication module compared to the group not receiving the communication module?	campuses, enrolled in “Basic Adult Health” course.	communication module (of 2.5 hours, 25 powerpoint slides on communication). Modules: Experiential modalities: letter to “Dear Death”; sensitisation exercises by viewing videos such as “In the Gloaming”; Attentive listening exercises; “Eliciting End of life goals” role-plays.	3) Demographic data 4) background data 5) post-test both groups were asked of “any clinical experiences with a dying patient since completing the previous survey?” 6) intervention group also asked to describe learning experiences with the communication module.	Limitations: small convenience sample (sample was too small to relate the variables to having a significant impact on the student’s attitude toward care of the dying), the intervention was introduced by the researcher who is also program director, which may have resulted in potential bias in the groups responses.
Bush (2012) Australia Education Initiatives	Study aims: to determine if the completion of a Oncology and Palliative care elective course aided a group of undergraduate nursing students in the clinical provision of palliative care.	Sample: 70 students who had recently completed the Oncology and Palliative Care Course at a Victorian University were randomly selected and sent to questionnaires. 51 returned.	Intervention: A single semester Oncology and Palliative Care Course guided by PCC4U outlines and recommendations, delivered for 3 hours each week.	Mixed Methods: Descriptive/explorative mixed methods study (Only results of phase1 of study available). Instruments: -Survey/questionnaire with qualitative comments. -Demographics.	Findings: Students perceived an ability to be clinically competent in the facilitation of Palliative care following an elective course in palliative care. -the course had a positive influence on students learning of palliative and end of life care. Limitations: small sample size, limited to a 3 rd year cohort from one university, participant self-selection into elective course indicates a potential bias towards palliative care Strength: Australian research.

LIMITATIONS

There are a number of limitations of the review that need mention. Although the search strategy included a number of search terms and databases, the search strategy may not have identified all the relevant literature on this topic, such as unpublished literature, since the review was restricted to published research studies only. The review was not restricted to English only publications, however, papers of relevance that were not in English may not have been identified. Also the focus of the paper was on teaching strategies in end of life care education, other teaching strategies may be used in practice, but not be published as research so these too may not have been identified. Nevertheless, this paper aims to be a comprehensive but not exclusive review of the current available research on end of life care education.

CONCLUSION AND RECOMMENDATIONS

The literature has highlighted that nursing students feel unprepared to deal with issues related to death and dying. Research found that schools of nursing are not adequately educating nursing students to care for patients at the end of life and this has been identified as a crucial reason for inadequate care. The paper reviewed literature available to examine how end of life care education has been delivered to undergraduate nursing students and discussed the research on modes of delivery and teaching strategies utilised in end of life care education.

Issues in end of life care education highlighted in the research include lack of end of life content in textbooks and lack of content on end of life care in the undergraduate nursing curricula. The issues identified in the available research include methodological issues of sample size and the scientific quality of the tools used. Interestingly, most of the identified research are of a quantitative (n=12) nature and the minority of these studies are of a purely qualitative (n=3) or a mixed method (n=3) nature. The gap identified is the lack of qualitative research on end of life care teaching strategies prompting a question as to how to effectively assess learning strategies for depth of learning experiences in end of life care education.

When implementing teaching strategies for end of life care education it is recommended that; 1) the level of the undergraduate nursing student; 2) the characteristics and demographics of the cohort; and 3) the experience with death and dying (either personal or professional) need careful consideration. Because undergraduate nursing student cohorts across the world vary significantly in characteristics, a number of teaching strategies are required to provide a range of learning experiences that meet all learners' needs.

Whilst many innovative teaching strategies have been implemented, using simulation on end of life education in undergraduate nursing programs appears to be an attractive option in providing quality learning experiences for undergraduate nursing students. The paucity of research on this teaching and learning strategy highlights the necessity of exploring this as an innovative means of providing meaningful experiences with end of life care and preparing students to provide quality end of life care in clinical practice. Part 2 of this literature review will provide a critical discussion on end of life care simulation.

The following section includes Publication 2:

Gillan, P.C., Jeong, S., & van der Riet, P.J. (2014b). End of life care simulation: A review of the literature. *Nurse Education Today*, 34 (5), 766-774. doi: 10.1016/j.nedt.2013.10.005

2.3 End of Life Care Simulation: A Review of the Literature

ABSTRACT

Key words: End of life care, education, simulation, nursing students.

Background: Simulation is an evolving pedagogical approach to teaching in many undergraduate nursing curricula, however, there is little published literature on end of life care simulation as an effective means of teaching nursing students about end of life care.

Literature Review Aims: To examine available literature on end of life care simulation.

Review Methods: An extensive literature search on end of life care simulation in the undergraduate nursing curriculum was conducted in CINAHL, Mosby's Index, Cochrane Database, Scopus, Eric via Proquest, and Medline. 6 research articles and 10 descriptive articles published between 2009 and 2013 that met the selection criteria are included in the review. **Findings:** Findings of these 16 articles are reported under 4 main themes: 1) Increased knowledge of end of life care through 'experiential learning'; 2) Impact of family presence on student learning; 3) the Debriefing imperative, and 4) Methodological issues raised from studies.

Conclusion: The findings of the studies reviewed support end of life care simulation as a strong and viable pedagogical approach to learning for its positive effects on knowledge acquisition, communication skills, self-confidence, student satisfaction and level of engagement in learning. However, the important factors including psychological safety of students and the costs involved require careful consideration. Research on the use of simulation in nursing is still in its infancy, further research using various research designs is required to adequately explore the issues surrounding end of life care simulation.

INTRODUCTION

This article is the second part of a literature review that explores the history and future of end of life care education for undergraduate nursing students. The first paper “End of Life Care Education, Past and Present: A Review of the Literature” (Gillan et al., in press) explored how end of life care education has been delivered since 1984 and to the present. Two main themes ‘Methods of end of life education delivery’ and ‘End of life care education initiatives’ were highlighted. A turning point is evident in the emerging use of simulation for end of life care since 2009 in an effort to help prepare students for undertaking quality end of life care in the clinical setting.

BACKGROUND

Simulation is defined as “An event or situation made to resemble clinical practice as closely as possible” (Jeffries, 2007, p. 28) and is categorized according to the level of fidelity or realism along a spectrum of low fidelity to high fidelity. Examples of low fidelity include the use of case studies or role-plays related to a particular situation. High fidelity simulation is defined as “the use of technologically lifelike manikins with provision for a high level of realism and interactivity” (Jeffries, 2007, p. 28).

The use of simulation in nursing education dates as far back as 1874 when anatomical models were used in the form of jointed skeletons (Nehring and Lashley, 2009). The formal use of manikins to enhance student learning began a century ago with the introduction of ‘Mrs Chase’ a full body static manikin in 1911 (Jansen et al. 2009). However, simulation only became popular in the 1950’s when it was realised that using manikins helped students put theory into practice (Roberts and Greene, 2011). In the 1960’s the use of low fidelity manikins such as ‘resusci-Annie’ became popular, and is still in use today (Roberts and Greene, 2011).

Since 2004 the use of high fidelity manikins has increased as an effective means to teach essential skills for nursing students. High fidelity simulation is viewed as an innovative pedagogical approach (Reilly and Spratt, 2007; Berragan, 2011) in a safe clinically realistic environment (Twigg and Lynn, 2012). Simulation contributes to improving critical thinking, clinical reasoning skills and problem solving skills without fear of causing harm to actual patients (Jansen et al., 2009; Sperlazza and Cangelosi, 2009). Further benefits include; 1) improving knowledge acquisition (Lapkin, Levett-Jones, Bellchambers & Fernandez, 2010b); 2) promoting understanding and application of cognitive and psychomotor skills (Bland et al., 2011; Feingold et al., 2004); 3) bridging the gap between theory and practice (Kopp and Hanson, 2011); and 4) refining communication and technical skills in interdisciplinary teamwork (Jansen et al., 2009). More importantly, there is strong evidence of high learner satisfaction with the use of high fidelity patient simulation (Lapkin et al., 2010a, 2010b). This

is significant because learner satisfaction may potentially enhance student's engagement and therefore, facilitate learning (Lapkin et al., 2010a).

However, the focus of most of this research is on acute or critical care nursing using scenarios related to emergency or advanced resuscitation situations (Feingold et al., 2004). It was not until 2009 that the use of simulation in end of life care education emerged.

AIMS

The aims of literature review were to 1) explore what literature exists on end of life care simulation in undergraduate nursing education and 2) critically discuss the issues related to end of life care simulation. This paper critically reviews the literature on end of life simulation and argues for its relevance in undergraduate nursing education.

REVIEW METHODS

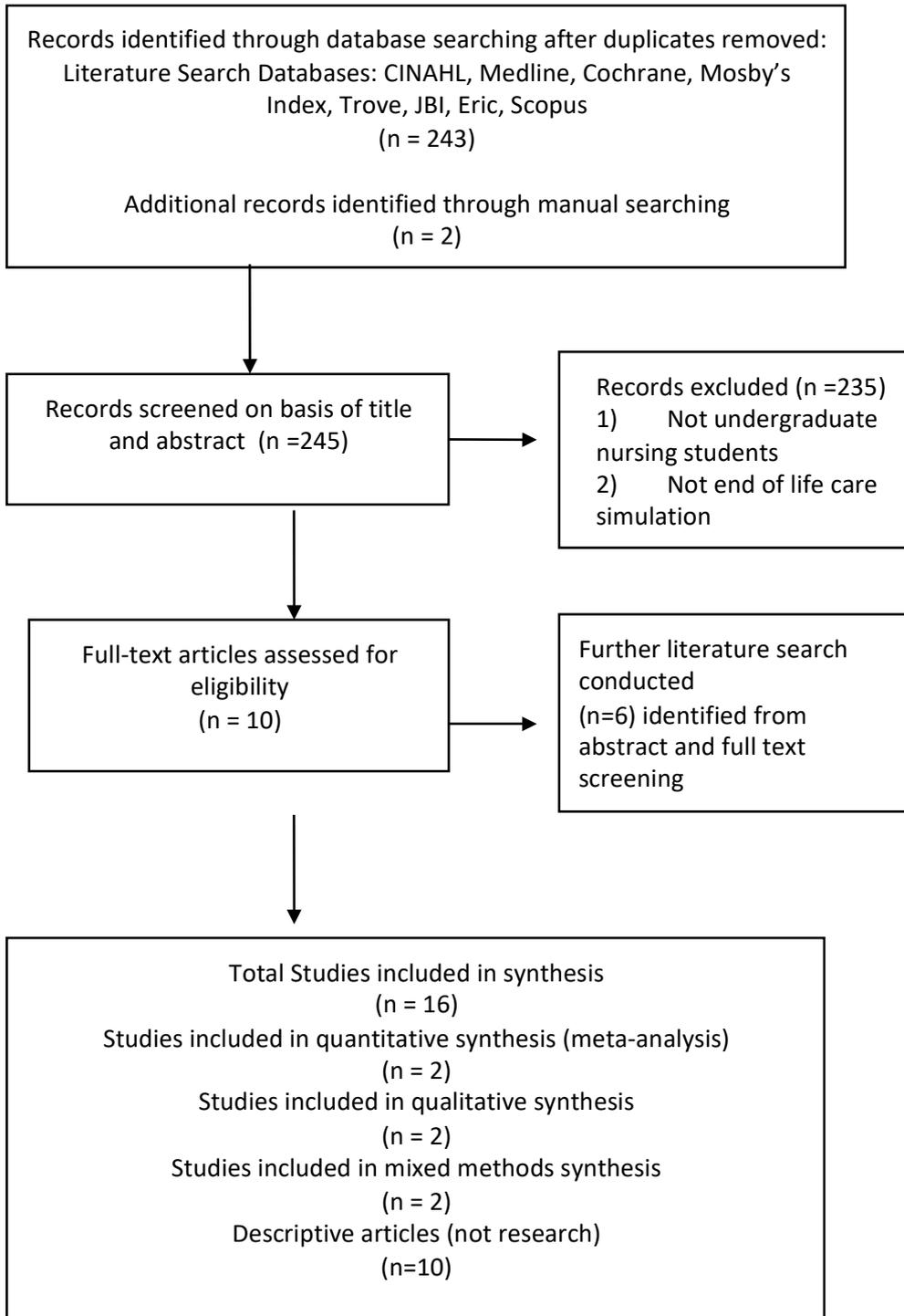
A search of published literature was conducted on CINAHL (Cumulative Index of Nursing and Allied Health Literature), Mosby's Index, Joanna Briggs Institute, Cochrane Database, Scopus, Eric via Proquest, Medline, and Trove. A total of 243 journal articles of potential use were identified. Key search terms and database results used are cited in Table 2.4. Two further articles were identified using a manual search of the relevant journals (n=245).

These articles were reviewed for the key search terms of "end of life care"; "simulation"; "high fidelity simulation", "simulated death", "death simulation", "end of life simulation" and "nursing students". Article abstracts were reviewed for content specifically on participants (nursing students) and methodology (use of simulation). A total of 10 articles met the inclusion criteria of: 1) end of life care simulation; 2) undergraduate nursing students. The remainder 235 articles were excluded because they did not relate to end of life care, simulation or undergraduate nursing students. Table 2.5 provides a decision flow diagram.

Table 2.4: Search terms and databases used in initial search strategy.

Search Terms:	“AND”	Database:	Number of articles identified after duplicates removed
Undergraduate Nursing Students/ Nursing Degree Students/ Bachelor Degree Nursing Students Baccalaureate Degree Nursing Students	End of life care/Palliative care/ Terminal care/ Hospice care/Hospital care/Acute care/ Residential aged care/nursing homes/long term care/long term aged care/ Geriatric care/Geriatrics/ Grief and loss/Grief and loss education/Grief and loss programs/Bereavement/ Bereavement education/ Bereavement programs/ Debriefing/clinical debriefing/end of life care debriefing/death and dying debriefing/ Death and dying/ death/ death and stress/dying patients/ Death education/death curriculum/ death curricula/ End of life care education/end of life care curriculum/end of life care curricula/ end of life education/end of life curriculum/end of life curricula/ Simulation/death simulation/ simulated death/ End of life simulation/End of life care simulation/ High fidelity simulation	CINAHL; Mosby’s Index; Joanna Briggs Institute; Cochrane Database; Medline; Scopus; Eric via Proquest; Trove	197 8 5 6 7 11 8 1
Total Results:			243

Table 2.5: PRISMA Flow Diagram



A further literature search conducted in early 2013 revealed a further 6 articles, demonstrating an increased interest in this topic. A total of 16 articles have been identified of relevance and are included in the literature review. Of these only 6 were original research articles, the remainder of these are descriptive articles that report on projects undertaken in end of life care simulation, using high fidelity and hybrid simulation strategies. Due to the limited amount of literature on this topic all the relevant literature on end of life care simulation in nursing education are included in the review. Table 2.6 provides a breakdown of literature by the publication type.

Table 2.6: Types of publications

Research Articles			Non Research Articles
Mixed Methods (n=2)	Quantitative (n=2)	Qualitative (n=2)	Descriptive articles (n=10)
Quasi-experimental mixed methods pilot study (Moreland et al. 2012)	A quasi-experimental design (Fluharty et al 2012)	Phenomenological research (Eaton et al 2012)	Leighton and Dubas 2009; Leighton 2009; Smith-Stoner 2009a; Smith-Stoner 2009b; Sperlazza and Cangelosi 2009; Kopp and Hanson 2012; Gillan, et al., 2013; Tuxbury et al 2012; Pullen et al., 2012; Hamilton 2010.
Pilot study of a single group pre/post-test design with focus group discussion (Twigg and Lynn 2012)	A quasi-experimental design (Swenty and Eggleston, 2011)	Focus groups (Ladd, et al, 2013)	

The identified literature was analysed using thematic analysis by the primary author. Identified themes were confirmed by the other two authors of the review. This process of peer review ensured rigour and trustworthiness of thematic analysis.

FINDINGS

Four main themes were identified from the literature; 1) Increased knowledge of end of life care through 'Experiential learning'; 2) Impact of family presence on student learning; 3) The debriefing imperative; and 4) Methodological issues raised from studies. Table 4 provides a summary of the key findings from the literature.

Increased knowledge on end of life care through 'Experiential learning'

Regardless of sample size, study design and methods, the literature reviewed report that students perceived an increased knowledge and confidence in providing end of life care. During the analysis and synthesis of the literature, the authors noted that this positive effect rely heavily on the scenario that has provided the participants with a more realistic and personal experience of dying process and imminent death.

Examination of the scenarios revealed a variety of chronic or terminal illnesses that include; middle aged woman with metastatic or advanced ovarian cancer (Leighton and Dubas, 2009; Ladd et al., 2013; Kopp and Hanson, 2012), chronic obstructive pulmonary disease (Sperlazza and Cangelosi, 2009; Pullen et al., 2012), metastatic bowel cancer (Twigg and Lynn, 2012; Gillan et al., 2013); lung cancer (Eaton et al., 2012; Moreland et al., 2012); unspecified metastatic cancer (Tuxbury et al., 2012); HIV/AIDS (Swenty and Eggleston, 2011); expected death by cancer or AIDS and unexpected death by myocardial infarction, respiratory distress syndrome or motor vehicle accident or by action or inaction by the nurse (Leighton, 2009); and successful and unsuccessful coded scenarios (Hamilton, 2010).

The students (n=120) in a teaching project conducted by Gillan et al. (2013) reported that end of life care simulation provided them with an avenue to actually witness a death in a simulated clinical practice setting and enabled them to visualise the role of the registered nurse. Similar results are reported by Kopp and Hanson (2012) that the participants (n=45 first semester junior nursing students) experienced the management of a patient with advanced ovarian cancer facing end of life decisions over three scenes. In this instance participants perceived that insights gained from simulation could be successfully transferred to clinical practice and improved participants' understandings of interventions used in end of life care. Furthermore, quantitative and mixed method studies found an increase from pre-test to post-test scores on various knowledge instruments (Fluharty et al., 2012; Twigg and Lynn, 2012; Moreland et al., 2012).

In addition, simulation provided the students with experiential learning. In qualitative studies, Eaton et al. (2012) and Ladd et al. (2013) found that hands on learning was associated with the student's perceived learning in a non-threatening, safe, controlled environment that

enhanced learning outcomes. In this instance students perceived that experiential learning took place through “action, feedback and interaction” of the simulation experience (Eaton et al., 2012, p. e6). Although not research, the student participants in Gillan et al.’s (2013) project also reported that simulation provided a “hands on” experience, making the caring role more realistic, while Leighton and Dubas (2009) found students reported hands on experience allowed them to synthesise information learned in the classroom.

Impact of family presence on student learning

What has become increasingly evident in the end of life care simulation is the inclusion of family in scenarios and the impact this has on student learning. Seven articles report on the use of either students or standardised actors portraying roles of family members to add complexity to the simulation scenarios and increase realism. Standardised actors played a family member in articles by Smith-Stoner (2009b), Tuxbury et al. (2012), and Eaton et al. (2012). Eaton et al.’s (2012) study which included the roles of wife and daughter (played by actors) reinforced that the family were as important as the patient when providing end of life care.

Others have used nursing academics to play the role of either daughters (Leighton and Dubas, 2009; Ladd et al., 2013; Kopp and Hanson, 2012) or patient’s wife (Pullen et al., 2012), while Twigg and Lynn’s (2012) simulation included the roles of wife and daughter played by the nursing academics.

In a more creative and interactive approach, several authors utilised students portraying roles of family members. Gillan et al., (2013) included students portraying the roles of daughter/son and granddaughter/grandson and highlighted approaching families of dying patients as a major theme. Students were given an opportunity, by playing the role of family members, to gain an understanding of how to approach and respond to family members during the dying phase of the simulation. In research by Swenty and Eggleston (2011), students played various family members, communicating with the nurse, these students empathetically experienced the support and comfort provided by the nurse. Participants playing unspecified family members, facilitated students learning how to care for terminally ill patients and their families (Sperlazza and Cangelosi 2009) and students portraying the role of the wife (Fluharty et al., 2012) provided the opportunity to practice communication skills.

Whether it was the students, standardised actors or nursing academics who played family members in the scenarios, it is conclusive that the inclusion of family members is important to promote therapeutic communication, holistic and culturally competent care, allowing students the opportunity to provide support and assist the family cope with feelings of grief.

The debriefing imperative

The importance of post simulation debriefing is highlighted in all of the 16 articles reviewed. In all of the reviewed articles the debriefing sessions occurred following the simulations in a format of group discussions. Debriefing sessions were audio recorded (Moreland et al., 2012) or video recorded and broadcast to remote observers (Smith-Stoner, 2009a), while some used video recordings of the simulation in the debriefing sessions to facilitate discussion (Smith-Stoner, 2009b; Gillan, et al., 2013; Moreland et al., 2012; Eaton et al., 2012).

The benefits of debriefing include; 1) an opportunity to address and affirm feelings and responses related to providing end of life care (Twigg and Lynn, 2012; Gillan et al., 2013; Ladd et al., 2013; Tuxbury et al., 2012) as well as address concerns and fears (Sperlazza and Cangelosi, 2009); 2) reflect on their own experiences (Gillan et al., 2013); 3) interpret feelings and responses of others (Ladd et al., 2013); 4) aid in understanding of content (Twigg and Lynn, 2012); 5) facilitate therapeutic communication (Gillan et al., 2013); 6) facilitate reflective learning (Kopp & Hanson, 2011; Gillan et al., 2013); and 7) allows an opportunity to discuss the difficult topic of end of life care (Tuxbury et al., 2012).

Nevertheless, in conducting simulation debriefing Smith-Stoner (2009a) advises that debriefing must be “tightly controlled” by focusing specifically on course and simulation objectives and allowing participants and observers to share feelings and emotions only in the closing moments of the debriefing as students tend to stray from simulation objectives. The author also suggests that the facilitator must redirect students to focus on clinical reasoning and learning rather than on trivial issues such as mistakes made during simulation.

Leighton (2009) also recommends that the facilitator must establish a safe, non-judgemental environment where participants feel free to confidentially share thoughts and feelings.

One emanating theme highlighted in debriefing, is ‘degriefing’. Degriefing involves the process of facilitating “open expression and reflection of emotions related to distress over loss” (Hamilton, 2010, p. e134). Provided by a supportive facilitator, degriefing allows students with “emotion-focussed responses” an opportunity to discuss concerns and facilitate exploration and expression of feelings related to the sensitive issues of grief and end of life care (Hamilton 2010).

Methodological issues raised from studies

In quantitative and mixed method studies, it is important to note methodological issues related to sample size and tools used to measure outcomes. For quantitative studies, the sample size was limited to 79 3rd year students in Swenty and Eggleston’s (2011) study, although, in Fluharty et al.’s (2012) study 370 senior nursing students participated in their quasi-experimental multi-site study. The sample size was also limited in the mixed method

studies, Moreland et al.'s (2012) study involved 14 junior nursing students, while Twigg and Lynn (2012) used similar numbers for their pilot study (n=16).

It is notable that some tools used to evaluate change in knowledge acquisition, communication skills, self-confidence, and student satisfaction are validated. Instruments used to evaluate knowledge acquisition have had content or face validity established, for example the "Knowledge related to end of life care instrument" (Fluharty et al., 2012); and the NCLEX style exam (Twigg and Lynn, 2012). The quasi-experimental multi-site study undertaken by Fluharty et al. (2012) used a validated assessment tool 'The End of Life Communication Assessment tool to examine the students' communication skills in working with end of life patients after the simulation. However a Cronbach's Alpha co-efficient of 0.7, indicates acceptable but stands at the end of a low degree of reliability.

Another issue noted is that the positive effects of simulation rely on self-report. In Fluharty et al.'s (2012) study, self reported communication scores were ranked as high reflecting the participant's perception that they had learned to communicate in this setting (Fluharty et al., 2012). Fluharty et al. (2012) also reported an increase in student self-confidence in caring for a dying patient following simulation. Although this study used a reliable instrument, one of the limitations of the study is again the self-reporting nature of this scale. Furthermore, given that students' perceptions were measured only on post-simulation, rather than pre and post, it is difficult to determine if the change was an effect of the simulation.

Table 2.7: Summary of literature findings

Author/s/ Year/ Country	Research Question/s	Sample	Simulation Procedures	Research Design/Methods	Data Analysis	Key Findings
Fluharty et al (2012) USA	<p>1) Is there an increase in students' knowledge from pretest to posttest?</p> <p>2) What is the level of students' self confidence in caring for a dying patient after the simulation?</p> <p>3)What is the level of students' self-reported communication skills in working with end of life patients after the simulation?</p> <p>4)Are students satisfied with the learning methodology for end of life issues and care of the dying patient?</p>	<p>Sample: n= 370 senior students enrolled in a medical-surgical course (convenience sample).</p> <p>Sample: 90.8% female; 7.8% male; mean age 27.3 years; 88.4% Caucasian; 23.5% Associate Degree, 60.5% traditional baccalaureate, 11.6% accelerated baccalaureate. Simulation experience- 64% (some experience), 26% (no experience).</p>	<p>Procedure:</p> <p>1)Powerpoint lecture-ELNEC instructor.</p> <p>2) 20 min simulation, 20 min debriefing, 20 min questionnaires.</p> <p>Simulation: 4-5 students random assign of roles (RN1, RN2, wife, observers).</p>	<p>Quantitative:</p> <p>Quasi Experimental design, Multi-site study (4 nursing schools in Midwestern USA). Instruments:</p> <p>1)Knowledge Related to End of Life Care Instrument (content validity by 12 expert nurse reviewers).</p> <p>2)Self Confidence in Caring for a Dying Patient in Nursing instrument.</p> <p>3)End of Life Communication Assessment Tool (content validity by12 expert nurse reviewers).</p> <p>4)Satisfaction with instructional method.</p> <p>5)Demographic data.</p>	<p>-PASW stats 17</p> <p>-descriptive statistics (demographic variables).</p> <p>-T-tests and ANOVA (pretest/post test).</p> <p>-Correlations (relationships between variables).</p> <p>-Cronbach's alpha (2 of the 4 instruments).</p>	<p>1)Knowledge instrument- Significant difference on post-test for all students in all programs from pre-test (pre-test mean 7.98; SD=1.48; post-test mean 9.15; SD=1.12), regardless of age, gender or simulation role. The observer role had the highest changes.</p> <p>2)Self Confidence Instrument-mean 6.86 (SD=0.61) suggests students believed they had the knowledge and skills required.</p> <p>3) Communication Assessment tool- mean 4.33 (SD=0.56) reflects that students perceived they learned how to communicate in this setting.</p> <p>4) Satisfaction with the Instructional Method questionnaire- mean 4.07 (SD=0.81) indicates student satisfaction with simulation. Strengths- a multi-site study. Limitations: 1) The quasi-experimental design- separate contributions of the simulation and the lecture in increasing knowledge not identified; 2)The self reporting communication tool- unable to tell if simulation actually improved</p>

Author/s/ Year/ Country	Research Question/s	Sample	Simulation Procedures	Research Design/Methods	Data Analysis	Key Findings
						communication skills. Post simulation measurement only of communication and self confidence; 3)The reliability and validity of some measurement tools not established prior to the study.
Leighton & Dubas, (2009) USA	Not research. Description of a high fidelity simulated clinical experience.	Participants: 16 students (sophomore, junior and senior); enrolled in elective course ("Caring in Times of Death, Dying and Bereavement") at one Midwestern college.	Teaching strategies: didactic methods; experiential strategies; simulation ('Simulated Clinical Experience (SCE) End of Life Care'). Scenario: simulator-middle aged woman with metastatic ovarian cancer (course professor played daughter). The scenario included death of the patient. Student preparation:	Not research.	Nil	Themes: 1) Impact of family presence: the presence of family enhanced realism of the simulation; 2) Value of realism: realistic nature of the experience; psychosocial needs of the patient and family enhanced realism; 3) Self efficacy: a challenging experience; faculty should consider that they had never cared for a dying patient before. Limitations: small numbers of participants.

Author/s/ Year/ Country	Research Question/s	Sample	Simulation Procedures	Research Design/Methods	Data Analysis	Key Findings
			patient history, notes, orders and preparation questions (one week prior to simulation). Group Debriefing and evaluation.			
Leighton (2009) USA	Not research. Three types of simulated death are explored; issues related to simulated patient death; psychological safety of students.	No sample	Three types of patient death simulated: 1) expected death; 2) unexpected death: may come as a surprise and may be the result of a crisis; 3) death as a result of an action or inaction by the student.	Not research.	Nil	Themes: 1) Psychological Safety of Students: ensuring psychological stress is recognised and dealt with appropriately. Pre-briefing and Debriefing processes are vital to promote psychological safety; 2) Pre-briefing: before the simulation (preparation activities, simulator orientation); 3) Debriefing: exploring feelings about the events that transpired during the simulation.
Smith-Stoner (2009) USA	Not research. Description of web based broadcasting.	Context: A rural nursing program, faculty and students across 2 counties (Southern California).	Simulations have focused objectives Debriefing: video of work used as a learning tool; broadcast to remote participants. Remote observers: chat room sessions; responses and questions discussed during debriefing.	Not research.	No analysis	Limitations: limited information on project (number of participants, roles played, little information on debriefing session).
Smith-Stoner	Not research. Report on the experience of	Sample not described.	Pre-simulation: selected readings, poetry.	Conceptual Framework: an author-developed	None.	Limitations: limited information on simulation (numbers of

Author/s/ Year/ Country	Research Question/s	Sample	Simulation Procedures	Research Design/Methods	Data Analysis	Key Findings
(2009) USA	caring for a simulated patient who dies and interacting with a family member (standardised actor).		Experiential strategies and Simulation. Simulation- last 10 mins of life; groups of 10 (in pairs); others observers. Post Simulation- reflection in writing, debriefing; reactions to simulations, evaluation of care. Evaluation: completion of CAD.	conceptual model ('Silver Hour' -30 minutes before and after death). Instruments: 1) Concerns About Dying Scale (CAD). Method: Nursing Education Simulation Framework (Jeffries 2007) used to integrate end of life content.		participants, roles played, scenario). Physical limitations in the simulation of death- eg skin temp or colour cannot change, advanced programming to simulate respiratory changes.
Sperlazza & Cangelosi (2009) USA	Not research. Description of simulated clinical experience using high fidelity simulators.	Participants: n=30 first year students (groups of 4-6), from a rural community college (ELNEC curriculum).	2 hour pilot simulation. Scenario: three scenes over 4 weeks; 1-2 students played the nurse (others played other roles or as audience). Roles changed each scene. Scene 1: ED with acute exacerbation of COPD symptoms; rapid deterioration; no ACD; patient intubated; family dynamics; Scene 2: patient on ward extubated, symptoms of end of life; caregiver stress; patient advocacy;	Framework for interaction with students developed, piloted and evaluated.	None	Evaluations revealed the need to prepare students for simulation experience, including the nature and possible impact of the simulation.

Author/s/ Year/ Country	Research Question/s	Sample	Simulation Procedures	Research Design/Methods	Data Analysis	Key Findings
			Scene 3: patient actively dying at home (last breath not drawn).			
Hamilton (2010) USA	Not research.	No sample.	Example Scenarios: 1) unexpected code (successful); 2) rapid deterioration and unsuccessful code, family present.	Not research	None	Themes: Debriefing and “Degriefing” are important. The Death Attitude Profile-Revised (DAP-R) as effective in addressing how well death is accepted. CAD Scale: effective in identifying students with high levels of anxiety and concerns about their own mortality.
Kopp & Hanson (2012) USA	Not research. Report on high fidelity simulation and a gaming simulation in an “Aging adult health course”.	First semester junior students (n=36-45).	Simulation: advanced ovarian cancer patient (end of life decision making); 3 scenes (3 hour simulation)-1) assessment and admission (modelled by RN’s). 2) end of life decisions (modelled by RN’s). 3) physiological changes. After death of the patient the RN’s role played care of the patient and family (faculty played role of daughter). Preparation for simulation- 4 EOL related questions.	Not research Framework: Doerr and Murray (2008) “Simulation learning pyramid”.	The teaching strategy evaluated with 2 questions (5 point Likert scale).	Students felt they had a better understanding of the interventions, communication techniques and what to expect with their first patient death. Importance of caring and providing comfort to the patient and family. Gaming- students developed awareness of the issues related to a terminal illness, the losses people suffer and the effects of those losses. Students felt they could transfer insights gained to real clinical situations. Limitation: No discussion on the quantitative results from the Likert scale.

Author/s/ Year/ Country	Research Question/s	Sample	Simulation Procedures	Research Design/Methods	Data Analysis	Key Findings
			Gaming simulation- groups of 4-5 played <i>Seasons of Loss</i> board game.			
Eaton, Floyd & Brooks (2012) USA	What are the perceived influences of an end of life simulation on senior level BSN students' home health and hospice practicum experience?	Participants: n= 10 senior level students (30 students invited to participate).	Simulation: 15/60 simulation sessions (filmed), in groups of 4- 5, roles of primary nurse, secondary nurse, nursing assistant, social worker and a recorder. NP in a hospice setting played by RN. Wife and daughter played by actors. Debriefing: critique of the filmed scenario. Written responses to 2 open ended questions. Following placement: 1 followup open-ended question.	Qualitative: phenomenological approach using Colaizzi Framework: simulation modelled after Jeffries (2005) framework.	Data Analysis: Colaizzi's method.	Strengths: Students required to deal with family conflict in regard to cultural beliefs; rigorous process of data analysis involving several steps and reading of transcripts 6 times. Trustworthiness: Confirmability established through an audit trail; the researchers bracketed bias concerning previous experience with elements related to the scenarios, home health and hospice. Transferability achieved through data saturation and an audit trail of the emerging themes. Limitations: All three researchers were course instructors- possible bias in data collection and student responses; an interval of 3-4 weeks in completing post placement questions may have caused some variability in recall of students lived experience. Themes: 1) Experiential learning: hands on learning in a non-threatening environment; 2) Affirmative outcomes: perception of a safe, controlled

Author/s/ Year/ Country	Research Question/s	Sample	Simulation Procedures	Research Design/Methods	Data Analysis	Key Findings
						environment, improved role confidence, communication, collaboration, teamwork and role definition; 3) Family as client: family dynamics, therapeutic communication, and holistic, culturally competent care.
Moreland et al (2012) USA	Does a simulation experience affect students' knowledge and self-efficacy related to care of the dying?	Participants: 14 junior students enrolled in a medical/surgical course from a private institution in the Northwest U.S (15% participation rate; 11 traditional, 3 accelerated; 13 females, 1 male; average age 20.8 years).	Pre-simulation briefing: (completion of pre-test instruments) participants listened to pre-recorded shift report; lab orientation. Simulation: initial assessment, the simulator exhibited changes in breathing at predetermined times, and deteriorated until the patient stopped breathing. Debriefing: recorded, post-simulation interview guide, viewing recording.	Mixed Methods: Quasi-experimental design pretest/posttest/pilot study. Instruments: - Knowledge Assessment Instrument (author developed). -Self-efficacy instrument Posttest instruments sent by email the following day allowing for reflection.	Scores on the knowledge Assessment instrument were totalled and averaged. T-Tests: to compare pre and post-test scores. Content analysis of qualitative comments from recorded debriefing session.	Knowledge: significant improvement (74%, mean=5.21 pre-simulation to 85%, mean=6.0 post-simulation, p=.003). Self-efficacy: a t-test showed that self-efficacy improved significantly post simulation (35.36 pre-simulation to 37.79 post-simulation, p=.05). Themes: 1) caring vs curing- difficulty with changing perspectives from curing to caring; 2) big picture- providing palliative care and the importance of this; 3) great expectations- expectation conflicts (role, performance, self-efficacy, the global experience). Conclusions: the data supports the hypothesis that student knowledge and self-efficacy increased following simulation. Limitations: small sample size.

Author/s/ Year/ Country	Research Question/s	Sample	Simulation Procedures	Research Design/Methods	Data Analysis	Key Findings
Twigg and Lynn (2012) USA	1-Is there a change in students' knowledge toward end of life care after a simulated experience using a human patient simulator? 2-Is there a change in students' emotional readiness in providing end of life care after a simulated experience using a human patient simulator?	Pilot study: n=16 (convenience sample of senior BSN students) from a large nursing school located in the Mid Atlantic region.	Intervention: viewing movies dealing with end of life care and group discussion on the nursing role in end of life care. Simulation: 2 groups of students providing care to patient with bowel cancer, who dies (one observer and one participant- roles reversed after first simulation). Simulation roles: primary care nurse, new graduate nurse, palliative care nurse, social worker and clergy (faculty played patient's wife and daughter). Family dynamics- daughter in denial, family conflict.	Mixed methods: single-group pretest/posttest design. Focus group. Instruments: 1)demographic questionnaire (experience with death and dying). 2) 8 question NCLEX style examination. 3) CAD 4) Focus group (1 week after the simulation and completed the posttest knowledge and CAD scale).	Independent variable: simulation experience with end of life care. Dependent variables: students' knowledge and emotional readiness to provide care to a dying patient.	Strengths: Validity of CAD discussed. Emotional readiness: no differences existed between students with experience and the CAD scale domains ($p>.05$). Men reported less stress and anxiety related to death when compared with women before the intervention ($t= -2.906$, $p=.012$) and after the intervention ($t= -2.558$, $p=.023$). The simulation approach increased stress and anxiety among some students (students not previously exposed to this content). Students were also in their final semester of nursing and were expected to enter the nursing profession as RN's within 6 months. Debriefing: allowed students to discuss their feelings and aided in understanding content. Limitations: single group approach increases the threats to the study's internal validity; small convenience sample.

Author/s/ Year/ Country	Research Question/s	Sample	Simulation Procedures	Research Design/Methods	Data Analysis	Key Findings
Ladd et al. (2013) USA	No clear research question	35 (three groups) 100% participation rate.	One day program (didactic teaching, role playing, and simulation). Simulation- death of Mrs Anderson (Hospice inpatient); 4 scenarios each followed by debriefing.	Qualitative: pre class focus group (semi-structured group interview) and post class focus groups.	Content analysis of field notes and transcriptions.	Themes: avoiding the subject; witnessing pain and suffering; finding comfort in memories of a “good death”; students felt that the simulation experience should precede clinical experiences. Limitations-one instructor withdrew at the last moment, affecting students participation.
Swenty & Eggleston (2011) USA	1)Do students perceive that active learning is present during simulation? 2)Is active learning important to the student during simulation? 3)Does the student perception indicate that fidelity is present in the simulation? 4)Is fidelity important to the student during simulation?	Participants: n= 79 students enrolled in 3 rd year medical- surgical unit (90% female; average age of 23.8 years) from a Midwestern public university.	12 hours of simulation (three 4 hour sessions of 4 scenarios). 4 scenarios: 1)perioperative care. 2)patient with lymphoma 3)a patient with a bleeding ulcer 4)a 50 year old patient with HIV and death of the patient (played by lab coordinator, family roles played by students). Part 1- assessment and communication. Part 2- 10 years later, dying of AIDs (Sim Man). 4-5 students played roles as nurses, family members, and	Quantitative: quasi- experimental pretest/posttest design. Instruments: 1)The Educational Practices in Simulation Scale (EPSS). 2)The Simulation Design Scale (SDS)- (construct validity by 10 simulation experts). 3)The Student Satisfaction with Learning Scale- (content validated by 9 clinical experts).	ANOVA tests (to answer each research question). Turkey's post- hoc test for significant F ratios to identify pair wise differences between the means for each simulation. A power analysis for all F-ratios.	Student's perceived the presence of active learning, presence of fidelity, satisfaction with learning and self- confidence with learning was higher for the HIV scenario than the other 3 scenarios. Limitations: sample- from one nursing course at one university; student roles were not formally tracked (correlations could not be made between the student roles and the student responses); self reporting of surveys considered students perceptions only.

Author/s/ Year/ Country	Research Question/s	Sample	Simulation Procedures	Research Design/Methods	Data Analysis	Key Findings
	5)Were students satisfied with the simulation experience? 6)Was self-confidence positively affected by the simulation?		observer who took notes, shared during the debriefing session.	4)The Self-Confidence in Learning Using Simulations Scale (content validity by 9 clinical nursing experts).		
Tuxbury et al (2012) USA	Not research-pilot project. Goal- to evaluate the use of live actors, as both patient and family members in an end of life simulation.	N=45 (2 active participants, 43 observers- second semester medical-surgical course).	Simulation and group debriefing: 54 year old Jewish woman with metastatic cancer hospice patient (patient played by theatre professor, daughters played by theatre students), faculty and students playing roles of nurses.	Not research	Anonymous Evaluations: Quantitative- 13 questions (Likert scale). Qualitative- open ended comments; reflective journaling.	All 13 items were rated as <i>strongly agree</i> or <i>somewhat agree</i> by more than 75% of students; 61% strongly agreed that they felt more confident and were able to recognise changes in the patients condition; 62% strongly agreed that they learned as much from observing as if they were actively involved; 65% strongly agreed that the program was a valuable learning tool.
Pullen et al (2012) USA	Not research	2006-2010: n=90 students (2 nd year advanced medical surgical course in the ADN program). 2011- 140 nurses and 25 allied health	2 day program- Day 1- Introduction: Preparation for simulation, IDT meeting, and patient interview. Day 2- Patient interview (standardised patient); Concurrent IDT meetings; Simulation: final moments of life- high	Not research	Evaluation of 7 Learning Outcomes (Likert scale).	Mean scores of 4.5 or greater were achieved in each outcome indicated that students were very satisfied with the learning experience and could apply concepts to clinical practice. Themes- symptom management; teaching the patient and family; listening closely; shared goals; respect wishes and opinions; power of presence and kindness;

Author/s/ Year/ Country	Research Question/s	Sample	Simulation Procedures	Research Design/Methods	Data Analysis	Key Findings
		students (not specified).	fidelity simulation and wife played by faculty; groups of 4-5 students at 5 concurrent stations, role-played nurse or an IDT member; Debriefing following simulation.			appreciation of different beliefs; death as part of living; appreciation for end of life care; less fear and more confidence in caring for a dying person; providing comfort through compassionate interventions; being an advocate; collaborating and better understanding of IDT roles; awareness of ethical issues.
Gillan et al (2013) Australia	Not research	N=120 3 rd year students (enrolled in compulsory aged care and palliative care units). During 5 day residential school, groups of 20-25 participated in simulation.	Doris- 89 year old lady with Metastatic bowel cancer. End of life care during dying scene. Groups of 4 students role-played daughter, granddaughter/son, RN and SN. Remainder participated as observers. Debriefing and Evaluation- video replayed and facilitated discussion.	Not research	Thematic analysis of student evaluations (voluntary and anonymous); 2 Likert scale questions and 5 open ended questions.	Themes: 1) Linking Theory to Practice; 2) Approaching Families of dying patients; 3) An encounter with death; 4) Hands on experience in a protected environment; 5) Importance of post simulation debriefing.

DISCUSSION

A review of literature on end of life care education suggests that undergraduate nursing students are not adequately prepared for end of life care (Gillan et al., in press). A number of innovative approaches to improve this situation have been reviewed and discussed in part one of this paper (Gillan et al., in press). End of life care education in undergraduate nursing programs has reached a new era with the introduction of simulation. The available literature on simulation in end of life care education has been reviewed critically, and the following points have implications for implementation and warrant further discussion.

Psychological Safety of Participants

One of the major challenges highlighted in the literature on end of life simulation is ensuring the psychological safety of the participants. In promoting psychological safety of participants, 4 key elements are highlighted in the literature reviewed. 1) Pre-briefing: pre-briefing may include preparation activities and should include informing students of the nature of the simulation (Sperlazza and Cangelosi, 2009), and that the simulator may or will die (Leighton, 2009); 2) Debriefing: debriefing is important in the learning process of simulation as it allows students to explore feelings about the events that transpired during the simulation (Leighton, 2009); 3) Degriefing: degriefing is highlighted as important in promoting the psychological safety of participants and allows students to explore and express feelings related to fears and grief (Hamilton 2010); 4) Stress and anxiety: although many papers report on the benefits of end of life care simulation, the findings by Twigg and Lynn (2012) suggest that simulation may cause stress and anxiety. Although only a small sample size (n= 16) was used in this instance, comparison of Concerns About Dying scores revealed that a simulation approach for end of life care increased stress and anxiety in some nursing students. The authors acknowledge that the stress may be a result of no previous exposure to this content in the undergraduate program and that students were in their final semester of nursing and about to enter the nursing profession as RN's within 6 months. The reality of the simulation may have helped students recognise the inherent stress in caring for a dying person. Regardless of this consideration, educators must be aware that end of life care simulation may have this undesired effect on some students and must take the necessary steps to provide support to these students, such as those already outlined in this discussion.

Barriers and limitations of end of life care simulation

Although this teaching strategy is described as innovative, and despite not being addressed in any of the literature described in this review, the barrier of financial cost is an important consideration.

First of all, financial costs of initial purchase, ongoing maintenance and equipment upgrade can be considerable (Jansen et al., 2009). Cost factors also include the cost of running the simulators, and training staff members in the use, upkeep and repair of simulation equipment (Rothgeb, 2008). Rapid advances in technology also means simulators must also be regularly upgraded further adding to the financial cost (Feingold et al., 2004).

Not only is cost an important factor but also a lack of qualified and adequately trained nursing academics to teach end of life care simulation is a further important consideration. High fidelity manikins that involve programming and running of clinical scenarios requires a high level of training and expertise. The amount of time required for facilitators to become skilled in simulation and to develop scenarios also needs to be considered. This is important since the greatest barrier to the use of simulation in the nursing curricula is considered to be the complexity and time required to implement and utilise this equipment (Gillan et al., 2013). Alternatively, using standardised patients also requires considerable knowledge and expertise and additional resources such as individuals to role-play team or family members are often required (Rothgeb, 2008).

A considerable limitation of simulating death is the physical limitations of the technology, for example manikins do not have the ability to change skin colour or temperature (Smith-Stoner, 2009b), display non-verbal communication (Lasater, 2007), or mimic advanced changes in respiratory patterns (Tuxbury et al., 2012). Realistic scenarios used have some effect to compensate this limitation but further study is required to establish knowledge and evidence on how to develop realistic scenarios, what it involves, and what students' personal experience will be.

LIMITATIONS OF LITERATURE REVIEW

Although the search strategy included a number of search terms and databases, the search may not have identified all the relevant literature on this topic. Since the review was restricted to published literature only, literature that has not been published may not have been identified. The review was not restricted to English only publications, however, papers of relevance that were not in English may not have been identified in the search strategies. Nevertheless, this paper aims to be a comprehensive but not exclusive review of the current available research on end of life care simulation.

CONCLUSION AND RECOMMENDATIONS

The findings of the studies reviewed support end of life care simulation as a strong and viable pedagogical approach to learning for a number of reasons which include an increase in knowledge acquisition, improved communication skills, improved self-confidence, an increased student satisfaction and level of engagement in learning. The inclusion of family

members in end of life simulation is important to promote therapeutic communication, holistic care, and supporting family in the grief process. One of the benefits of end of life care simulation in qualitative studies was 'experiential learning' which facilitated students to 'link theory to practice'. Self-confidence and self-efficacy were the notable outcomes of quantitative studies. However, none of these are clinically tested and measured. Given the psychological safety of students is essential and the cost involved in end of life care simulation can be significant, the implementation of end of life care simulation as a teaching strategy warrants careful consideration.

2.4 Updated Literature Review

The previous sections 2.2 and 2.3 have provided two comprehensive literature reviews on end of life care education and end of life care simulation up until the time of publication of these papers in 2014. The next part of this chapter reveals the most current literature available on end of life care simulation from 2013 to 2018. The overlap of this time period (from 2013 to 2014) is provided to ensure no literature of relevance is missed from the time of journal article submission in 2013 to publication in 2014.

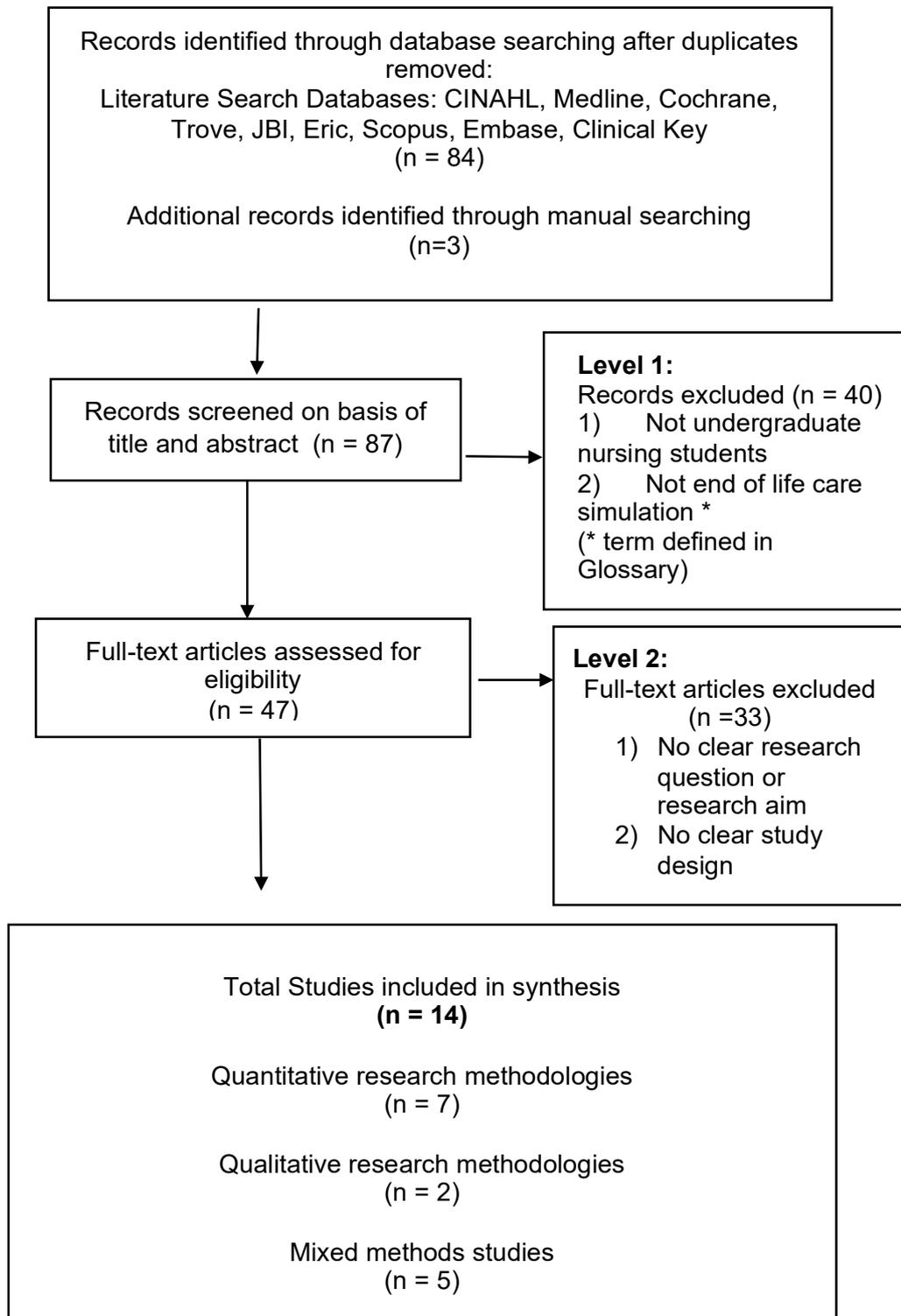
2.4.1 Review Methods: Literature Search Strategy

This updated literature search includes the same search strategy used in the previous publication (see Table 2.8: Literature Search Flow Diagram). The following search terms were used as inclusion criteria for this updated literature search:

- 1) Undergraduate nursing students/Nursing degree students/Bachelor degree nursing students/Baccalaureate degree nursing students; and
- 2) End of life care/ Palliative care/ Terminal care/ Hospice care/ Hospital care/ Acute care/ Bereavement/ Death/ Death and stress/ Death and dying/ Death education/ Curricula/ Curriculum/ Undergraduate nursing programs/ Debriefing/ Loss and grief/ Geriatrics/ Long term aged care/ Residential aged care/ Nursing homes; and
- 3) Simulation/ Simulated death/ Death Simulation/ End of life simulation/ End of life care simulation/ High fidelity simulation.

The inclusion and exclusion criteria from the previous publications were applied to this updated literature search. Results of this new literature search are represented in the following flow diagram (Table 2.8).

Table 2.8: Literature Search Flow Diagram



2.4.2 Findings of Updated Literature Search

A total of 14 recent research articles were identified that met the inclusion criteria. Half (n=7) of the research papers identified from this literature search were quantitative studies using primarily quasi-experimental research design. Five were mixed methods and only two were qualitative studies. These research articles revealed a number of themes that depicted the current landscapes of end of life care simulation.

2.5 The Current Landscapes of End of Life Care Simulation

Review of the updated literature on end of life care simulation revealed the five primary themes of: improved attitudes toward caring for patients and families at the end of life; perceived improved competence and comfort in providing end of life care; reduced anxiety in caring for patients at the end of life; increased preparedness for providing end of life care; and the emotional aspects of end of life care simulation.

From the literature currently available on end of life care simulation, the methodological and simulation design issues identified from the previous literature review on end of life care simulation (Gillan et al., 2014b), are still a major gap in end of life care simulation.

These findings from this updated literature from 2014–2018 are integrated and synthesised with the findings of my research study in Chapter Five.

2.6 Recommendations and Justifications of Study

Findings from a comprehensive review of the literature undertaken for this research have shown that undergraduate nursing students continue to report lack of preparedness for end of life care (Gillan et al., 2014b). While there has been an effort to improve this preparation through the use of end of life care simulation there are still significant gaps within this teaching methodology.

Although research on end of life care simulation has had an increasing presence in the literature since its emergence in 2009, 10 years later, there are still limited numbers of these studies in comparison to the large numbers of studies done on simulation in general. This comprehensive review of the literature on end of life care simulation found a total of 20 research articles on end of life care simulation (six research articles identified from Gillan et al., 2014b and 14 from this updated literature review). Not only are low numbers of research on end of life care simulation evident, but more significantly, there is evidence of low numbers of qualitative research. A total of only four qualitative papers have been identified. These papers include two phenomenological studies (Eaton, Floyd, & Brooks, 2012; Venkatasalu

et al., 2015); one focus group study (Ladd et al., 2013); and one narrative inquiry article from my own study (Gillan, van der Riet, & Jeong, 2016). Therefore, there is still a significant gap in the research on end of life care simulation, especially qualitative research exploring students' stories of experiences with this important teaching methodology. Research, in particular narrative inquiry studies that explore students' experiences and stories with end of life care simulation are required. Furthermore, simulation needs to include a variety of scenes and roles within a continuum to provide holistic end of life care simulation experiences.

2.7 Conclusion

In conclusion, this chapter has situated my research study within the relevant evidence based literature. Previous research in the area of end of life education and simulation has been evaluated and demonstrates a gap in the qualitative literature. This literature review provides justification for my research and the research methodology used.

In the next chapter of my thesis (Chapter Three), I will discuss the research methodology used to unpack my research puzzle (and weave together the fabric of my quilt) of understanding undergraduate nursing students' experiences with end of life care and end of life care simulation.

Chapter Three: Research Design

3.1 Introduction

In this chapter, I provide an overview of the research design and outline the research methodology of narrative inquiry, utilised to unpack my research puzzle and piece together the fabric of my quilt, “What is the undergraduate nursing students’ experience with end of life care and end of life care simulation?”

Narrative inquiry is an interpretive paradigm of qualitative research that focuses on the understandings and meanings of the study participants (Grbich, 2004). Within an interpretive paradigm, the researcher and the ‘researched’ work alongside each other and in relation to each other, where life events are “embedded in contexts that overlap in time and space” (Grbich, 2004, p. 163). As a relational methodology, the researcher negotiates a relationship with participants and attends to participants’ lives and experiences (Clandinin et al., 2015).

Central to narrative inquiry is Dewey’s (1938) notion that experience (an ontological assumption) and reality of experience can be known by studying lived experiences (an epistemological concept) (Caine, Estefan, & Clandinin, 2013). Ontology and epistemology aspects concern the person’s worldview (Park, Caine, McConnell, & Minaker, 2016) and are part of the methodological and philosophical assumptions of narrative inquiry.

3.2 Definition of Narrative Inquiry

Narrative inquiry is defined as “the process of collecting information for the purpose of research through storytelling” (van der Riet, Dedkhard, & Srithong, 2011a, p. 659). As Caine et al. (2013, p. 584) assert “we live storied lives on storied landscapes”. People interpret their worlds and define themselves through stories (Reimer Kirkham, Van Hofwegen, & Hoe Harwood, 2005). Narrative inquiry is the “reconstruction of a person’s experience in relationship both to the other and to the social milieu” (Clandinin & Connelly 2000, p. 5). For narrative inquirers the stories and the person are always visible in the study (Clandinin & Connelly, 2000), and stories are always “partial, contextual, temporal, embodied and filled with emotion” (Clandinin, Huber, Steeves, & Li 2011, p. 36).

As Connelly and Clandinin (2006, cited in Clandinin, Pushor, & Orr, 2007) state:

Arguments for the development and use of narrative inquiry come out of a view of human experience in which humans, individually and socially, lead storied lives. People shape their daily lives by stories of who they and others are and as they

interpret their past in terms of these stories. Story ... is a portal through which a person enters the world and by which their experience of the world is interpreted and made personally meaningful ... Narrative inquiry, the study of experience as story, then, is first and foremost a way of thinking about experience. Narrative inquiry as a methodology entails a view of the phenomenon. (p. 22)

Narrative inquiry is both the phenomenon under study and the methodology used to study the phenomenon (Caine et al., 2013; Clandinin, Murphy, Huber, & Orr, 2010). Narrative inquiry is an important method of inquiry that helps to unpack the research puzzle, or phenomenon of lived experiences (Clandinin & Connelly, 2000; Clandinin & Murphy, 2009). The phenomena of experience, for my research, are storied experiences of undergraduate nursing students with end of life care and end of life care simulation.

While there are other qualitative research methodologies within an interpretive paradigm, such as phenomenology, ethnography and grounded theory (Clandinin & Connelly, 2000), there are distinct differences that set narrative inquiry apart from these methodologies. Grounded theory places emphasis on the exploring the phenomenon under study in real world contexts (Grbch, 2004). Ethnography, on the other hand is focused on describing a group or a culture through emersion and engagement in fieldwork within the group under study (Thorne, 2000). Finally, phenomenology, seeks to discover the underlying structure and 'essence' of an experience (Thorne, 2000). While some researchers consider phenomenology and narrative inquiry to be similar methodologies within an interpretive paradigm (Thorne, 2000; Grbch, 2004), there are some significant differences that have led me to choose narrative inquiry as the preferred methodology for this study.

First and foremost, narrative inquiry is a way of understanding experience (Clandinin & Caine, 2008), that allows for the 'intimate' study of individuals' experiences over time and in context, where researchers attend to the three dimensions of temporality, place, and sociality (Clandinin & Caine, 2008). Narrative inquirers view time along a continuum of past, present and future (Lindsay, 2006). However, within phenomenology there is temporal tension, the phenomenon is studied as it is in the present, or "past-present-future conflated in a present moment" (Lindsay, 2006, p. 36).

Additionally, narrative inquiry, as a relational methodology, places emphasis on engagement between the researcher and the participant (Clandinin & Caine, 2008). As Lindsay (2006, p. 37) suggests "researchers are autobiographically and temporally in the situation being studied, in relationship with co-participants". This is in contrast to phenomenology where the researcher sets aside, "brackets" or "reduces" their own preconceptions to allow them to work inductively (instead of interpretively) with the data to generate descriptions and

conceptualisations (Thorne, 2000) and are not autobiographically implicated within the study (Lindsay, 2006).

Narrative inquiry is a relational methodology (Caine & Steeves, 2009; Clandinin, 2013), experienced over time and across places (Caine, 2010b). In telling participants' stories, I also include my own stories and observations collected throughout the data collection process. These include my own researcher reflections on what the participants' stories meant to me hearing the stories and walking alongside participants entering into their own lives and experiences vicariously (Maher, 2003). In this manner, participants' stories are co-constructed with me as the researcher (Clandinin, 2005). As research participants generously share their stories, the researcher travels alongside them (Caine, 2010a, 2010b) and the researcher and participant walk the journey together (Maher, 2003). This walking or travelling alongside participants is relational to the concept of living alongside (Clandinin et al., 2006; Clandinin et al., 2016) and being part of the lives of participants as they unfold, in the "living out of stories" (Clandinin, 2006, p. 47). For me, this living alongside encapsulates travelling with participants to their worlds (Huber et al., 2013; Lugones, 1987) as they share their experiences with end of life care and end of life care simulation.

The importance of narrative to describe nurses' experiences cannot be underestimated, especially for those nurses who are involved in end of life care. Summed up by one researcher's participant "Nursing has granted me the privilege of intimately touching and being touched by those in my care" (Hudacek, 2008, p. 127). This comment highlights the relational nature of nursing and stories told during narrative inquiry.

The use of narrative in research, I believe, can provide a medium that facilitates the beauty and richness of stories told, expressed freely and individually by participants in a language of their own. The experiences of people describing events in relation to end of life offers uniquely rich and beautiful dialogue and discourse that can provide researchers with very personal accounts of these very powerful and privileged moments. Only by hearing the personal stories of students' experiences with death and dying can educators and facilitators hope to understand these feelings and emotions and by doing so, prompt means of improving experiences for students and the patients and families in their care. Improving experiences with end of life care underpins the justification of my research, which I address in detail in the following section.

3.3 Justifying My Work

Narrative inquirers must attend to three levels of justification when undertaking research: personal justification, practical justification and social justification (Clandinin & Connelly,

2000; Clandinin et al., 2007). In this section I discuss each level of justification and outline how I address each one in my research.

1) Personal justification: is the importance of the researcher situating themselves in the study, including the researcher's relationship to the research and the interest in the inquiry (Clandinin et al., 2007). In my research, my own first experiences with end of life care were filled with uncertainty and lack of preparedness. My own experiences inspired my passion in end of life care and my commitment to improve experiences for undergraduate nursing students, patients and families.

2) Practical justification: involves how the research will be insightful to change and how the researcher will think differently about their own and others' practices (Clandinin et al., 2007). My research encompassed and drove end of life care simulation as an important means of preparing students for end of life care and was my attempt to contribute to the body of knowledge on end of life care education. This study has the potential to further inform teaching and simulation on end of life care, improve experiences with end of life care simulation and, therefore, impact on end of life care, for students, patients and families.

3) Social justification: includes looking at larger social and educational issues that the study might address (Clandinin et al., 2007), as both theoretical justification and social action and policy justification (Clandinin & Huber, 2010). While analysing the data, using a narrative inquiry approach, I have sought to unpack the research puzzle of undergraduate nursing students' experiences with end of life care and end of life care simulation and, therefore, further inform how these experiences can be improved for nursing students, dying patients and their families. This research will also support and inform nurse clinicians and nurse educators who have professional and social responsibilities to improve end of life care experiences for all. Furthermore, the stories from undergraduate nursing students will add new knowledge to the field of end of life care education and end of life care simulation.

3.4 Shaping Design Considerations (My Research Puzzle)

To piece together the fabric of my quilt and unpack my research puzzle of: "What is the undergraduate nursing students' experience with end of life care and end of life care simulation?", I followed three research aims, which were to:

- 1) Explore the end of life experiences, personal and professional, of undergraduate nursing students prior to end of life care simulation;
- 2) Explore experiences of undergraduate nursing students with end of life care simulation; and

- 3) Investigate the impact of end of life care experiences and end of life care simulation on the undergraduate nursing student.

In unpacking my research puzzle I needed to understand the students' experiences with end of life care (personal and professional) and end of life care simulation. This began, for me, a lengthy, convoluted and often entangled process of developing, planning and implementing the simulation scenarios. In the next section, I outline the evolving stages of the simulation implementation, before I explain the research data (field text) collection procedures.

3.4.1 Setting the Simulation Scene

The simulation design and inspiration arose when I started working in a school of nursing in a university where immersive simulation was being integrated into the undergraduate nursing curriculum. Combining my passion for palliative care and end of life care, and my own inadequate first end of life care experience, I was motivated to introduce students to simulation scenarios in palliative care and end of life care. Inspired by the potential of end of life care simulation, I started working with ideas and wrote the Doris scenario. The scenario was designed to meet the learning outcomes of the unit of study, HSNS314: Palliative Care. During this compulsory 3rd year unit of study, students partook in the end of life care simulation as a standard teaching and learning strategy during a compulsory intensive residential school, during Semester 1, 2013. This unit of study was delivered by flexible delivery mode, where the majority of learning was done by external mode using the university's online learning platform (Blackboard). To complete the unit of study, students were required to attend a four day compulsory intensive residential school to attend lectures, tutorials and simulation classes.

3.4.2 Pilot Testing the Scenario

Before undertaking this research, the simulation was firstly pilot tested to a group of nursing students (n=120) during an intensive residential school that took place over six days at the school of nursing during Semester 1 in 2011. During these six days, students enrolled in the unit (HSNS314), attended lectures, tutorials and a simulation session on end of life care. Following solicited feedback from students the simulation was found to be beneficial for nursing students and gave them an opportunity to experience end of life care in a safe and supported environment. Findings from the pilot test were published in *Nurse Education Today* (Gillan, Parmenter, van der Riet, & Jeong, 2013). This publication outlines the project description and findings from qualitative and quantitative student evaluations.

Following the pilot testing of the simulation during 2011, the simulation was further developed in preparation for the research participants who undertook the simulation in 2013. Feedback provided from the pilot test informed the following changes that were implemented before the research commenced two years later. Firstly, the pilot simulation involved four scenarios: (Scenario 1: Pain management; Scenario 2: Symptom management (nausea and vomiting and constipation); Scenario 3: Terminal restlessness and general nursing care at the end of life; and Scenario 4: The dying scene). After feedback from students regarding group sizes, the scenarios were increased to five clinical stations, which corresponded in separating the symptoms from Scenario 2 into two distinct scenarios (one scenario on constipation and one scenario on nausea and vomiting). The final change was made to simulation debriefing. During the pilot of the simulation, the dying scene was video taped and played back to students during the debriefing session. However, problems arose with the audio-visual equipment which prevented screening all of the video recordings. Time also became a factor with playing back video recordings and was found to be a barrier to the overall simulation debriefing experience. The video recordings were consequently removed from the simulations. The following section provides an overview of the simulation scenarios that the students from my research undertook in 2013.

3.4.3 The Doris Scenario

Doris, played by standardised patients, is 89-years-old and has a history of Dukes C bowel cancer with metastatic spread of secondary cancer to the liver and lungs (see Appendix C: Doris Scenario Background). Doris is no longer having any active treatment and the focus now is on quality of life and symptom management. The scenario follows Doris's journey as she starts to enter into the final phase of her life and follows her journey till the moment of death. The students followed Doris through five separate unfolding scenarios during the simulation experience. The scenarios involved Doris, her son, two RNs and other family members. Working in groups of three or four, students played the role of RNs in pairs, or as observers, and rotated through each of the five scenarios simultaneously and sequentially.

The unfolding simulation scenarios were:

Scenario 1) Pain management – Doris has been admitted to hospital with increasing pain. In this scenario students assess Doris for her level of pain and use critical thinking to decide what strategies need to be undertaken to manage her pain successfully.

Scenario 2) Constipation – three days have passed since her admission to hospital and Doris has not had her bowels opened during this time. During this scenario, students must assess

Doris for constipation and complications of constipation, and take action to address Doris's needs.

Scenario 3) Nausea and vomiting – another three days pass and Doris's health has visibly deteriorated. During this scene, Doris is vomiting and is increasingly distressed by her deteriorating health. She asks students some difficult questions (e.g. "Am I dying?") that they need to address while also assessing and managing her symptoms.

Scenario 4) The unconscious patient – another five days have passed and Doris (played by a low fidelity manikin) is now unconscious. Doris has her son, Darren, by her bedside. On entering through the curtains, students find Darren to be anxious, asking lots of questions about Doris's condition and wanting to know when she will die. Students in this scenario must provide support to Darren and respond to his questions whilst attending to the care of Doris as an unconscious patient.

Scenario 5) The dying scene – at the beginning of this scenario, students are pre-briefed in their small groups about their roles in this scene. Unlike the previous scenes, students also play the role of family members sitting by Doris's (played by a high fidelity manikin) bedside, waiting for her to pass away. The two students playing RNs provide support to Doris's family and are present whilst Doris takes her final breath. This scene also involves responding to initial reactions of the family when Doris dies.

3.4.4 The Simulation Landscapes

During the four day intensive residential school, the simulations took place in the two nursing laboratory spaces: 1) the clinical nursing laboratories; and 2) the simulation laboratory. The clinical laboratory spaces had three beds opposite and facing each other, separated by curtains (similar to Florence Nightingale style wards). For the first four scenarios, four of the six beds were arranged as a standard shared hospital ward, with curtains pulled around each bed to ensure privacy and prevent students getting a 'sneak peek' of other scenarios ahead of time. The final scenario, the dying scene, took place in the simulation laboratory with a high fidelity manikin playing the role of Doris. Designed to mimic a private hospice room, the simulation laboratory was set up as a private room with flowers, a patchwork quilt and comfortable chairs by the bedside.

On the first day of the intensive residential school and prior to the simulation, all students attended an hour-long lecture on end of life care, signs of imminent death and after death care. The lecture included the simulation scenario which was posted on the HSNS314 online Blackboard site. Previous tutorials and lectures during the intensive residential school covered symptom management. The simulation ran every afternoon of the intensive

residential school to enable the entire cohort of students (n=128) to undertake the simulation as a standard teaching strategy. A total of five groups of nursing students attended the simulation (two groups of 28 students; two groups of 27 students; and finally, one group of 18 students to accommodate the research participants). The recruitment strategy is outlined in Section 3.5.

3.4.5 Simulation Pre-brief

On the day of the simulation all participants of the study were given an orientation to the simulation and a pre-briefing session of approximately 15 minutes. The pre-brief provided students with an overview of what to expect during the simulation including the fact that Doris would pass away in the final scenario. The unfolding scenario, rotation through the scenes, and the students' roles in each scenario (playing the role of the RN in pairs with the remainder of the group playing the role of observer) were explained. Students were then randomly assigned into five groups of three or four students (18 students in groups of 4, 4, 4, 3, 3). Timing of each scene (10 minutes), playing scenes in real time and signalling 2 minutes before the end of each scene, and flows of each rotation, were also explained. The "Basic assumption" of simulation: "We believe that everyone participating in activities at [the University of New England (UNE)] is intelligent, capable, cares about doing their best and wants to improve" (Center for Medical Simulation, 2004, para 2) was read out by one of the students to remind students to be respectful of each other, do the best they can, and not discuss anything that happened in the simulation outside the simulation spaces.

3.4.6 Simulation Debrief

After completion of all five scenarios simultaneously and sequentially, the students were gathered together in the simulation debriefing room for the post-simulation debrief. Firstly, students were asked how they found the simulation experience. This initial opportunity for response allowed students to reveal what were the most obvious or perhaps the most confronting aspects of the simulation. After students briefly discussed their initial responses to the scenarios, the post-simulation debriefing addressed each scenario progressively, discussing what unfolded within each scenario and addressing the learning objectives of the simulation (derived from the learning outcomes of the unit of study).

3.5 Relational Ethics

Prior to conducting this research, I obtained ethics approval through the University of Newcastle, Human Research Ethics Committee (HREC reference no. H-2012-0059) (Appendix D: University of Newcastle HREC Approval) and ratification of ethics through the University of New England, Human Research Ethics Committee (Approval no. H-2012-0059) (Appendix E: University of New England Ratification of HREC Approval). Prior to undertaking the research participants were emailed a letter of invitation to participate in this research (Appendix F: Letter of Invitation to Participate in Research Project); a Participant Information Sheet (Appendix G: Participant Information Statement for Research Project); and a Consent to Participate form (Appendix H: Research Consent Form). The aim of the participant information sheet was to ensure that participants fully understood the information provided and that participants were fully informed about the research before signing the participant consent form.

Informed consent, voluntary participation and right to withdraw from the study:

students were provided with a comprehensive participant information sheet that clearly outlined the research study, the voluntary nature of student's participation and the freedom/right to withdraw from the study at any time without giving any reason and without any consequence or impact upon student's studies.

Protection of participants' confidentiality, privacy and anonymity:

Participant confidentiality, privacy and anonymity was ensured by using pseudonyms throughout transcribing and reporting findings of the study. The researcher and an employed transcriber transcribed the interview data. The employed transcriber signed a confidentiality agreement before transcribing data. Participants were reassured in the participant information form that they will not be identified in any reports arising from the project and that pseudonyms would be used in publications or conference presentations derived from the research.

Role of the researcher:

Participants were informed that the study would be undertaken by the student's lecturer teaching into the unit of study (HSNS314). To alleviate the potential issue of an unequally balanced power relationship over the students and the possible perception of coercion or dependency, I guaranteed that I had no responsibility or authority over awarding marks for the students participating in the research. These students were also assured that participation or non-participation would not impact on results for their final semester of study.

Risks or Benefits:

Students were informed that there was unlikely to be any immediate or direct risks associated with the research. However, students were advised that should they become distressed or uncomfortable during the simulation or during the interview, the simulation or recordings would be stopped and emotional support provided by a pre-

arranged counsellor from the University of New England, independent of this research. Participants were also reminded that they should reconsider participation in this research if they have had a recent or any unresolved issues of grief.

Students were also advised that there would be no direct benefits in undertaking this research, however, it is believed that participation in interviews can be therapeutic. It is hoped that future nursing students, nurses and patients will benefit from new knowledge that this study will generate.

Storage of data and security of information: All de-identified printed data obtained, including records and transcriptions of interviews, were stored securely in a locked filing cabinet in the researcher's office, and all audio and visual recordings obtained during the data collection were kept as a single electronic copy on the researcher's laptop computer and password protected. All information obtained during the study was only used for this study. Only the researcher and the supervisors had access to the files to ensure privacy of information. At the conclusion of the study all data will be stored in a secured location at the School of Nursing and Midwifery, University of Newcastle, for a period of five years before being destroyed.

3.6 Finding Participants and Co-composing an Inquiry Field

A convenience sample of the cohort (n=128) of 3rd year undergraduate nursing students enrolled in a unit of study titled HSNS314: Palliative care, were emailed a letter of invitation to participate in this research; a Participant Information Sheet; and a Consent to Participate form approximately 10 weeks before the intensive residential school. A reminder letter was sent out six weeks later due to initial lack of response (Appendix I: Reminder Letter). Completed Consent to Participate forms for the research project were returned to me, as the researcher, by either email or by mail. A total of 18 students volunteered and consented to participate in this research (see Appendix J: Demographics of Participants).

3.7 Collection of Field Texts

Two phases of data collection were used to collect field texts (Phase One; Phase Two). Phase One, Part One, involved video recording of the dying scene of the simulation; Phase One, Part Two, involved audio recording of the simulation debriefing. This phase also included the researcher's participant observation field notes from the simulation dying scene and the simulation debriefing.

Phase Two of data collection involved individual semi-structured participant interviews of approximately 40–100 minutes in duration and six to ten months after the simulation experience. Additionally, participants were invited to bring along to the interview a personal item of meaning to stimulate discussion on end of life care experiences. Items of meaning brought by students to the participant interview were included in the analysis of the interviews.

3.7.1 Phase One: Part One – Video of Simulation Scenario 5: The Dying Scene

All students participated in all five scenes of the simulation. The final scene included the patient dying. During this scene, students undertook roles of family members as well as two RNs, working together. The high fidelity manikin played the role of Doris, and family, played by the students in the study were situated by Doris's bedside holding her hand while she took her last breaths. This scene lasted approximately 5–7 mins and was video recorded for the duration of the scene: from before death, during the time of death and after death including participants' initial responses at the time of death.

3.7.2 Phase One: Part Two – Debriefing Audio Recording

Immediately following the simulation, participants were gathered together in the simulation debriefing room for the simulation debrief. The simulation debriefing was audio recorded on two devices (an iPad and a digital recorder) from the time students all returned to the room at the end of their last scene, until the end of the debriefing session and the close of the simulation experience. Simulation debriefing lasted approximately 40 minutes.

Participant observation field notes were collected to capture the experience of end of care simulation during the dying scene and then immediately after the simulation during debriefing sessions. Connelly and Clandinin (1990) suggest that field notes collected during participant observation are one of the primary tools of narrative inquiry work. Field notes taken during this time were for the purpose of recording physical and verbal behaviour (Mulhall, 2003). This field text provided further insight into the journey experienced by the participants in relation to verbal and non-verbal messages revealed. Additionally, field notes promoted trustworthiness of the research ensuring dependability, credibility and confirmability of research findings. The significance of field notes in ensuring trustworthiness is discussed further as this chapter unfolds.

3.7.3 Phase Two: Participant Interviews and Items of Meaning

In my research, I used semi-structured interviews to capture participants' simulated, personal and clinical experiences with end of life care (Appendix K: Participant Interview Schedule). Semi-structured interviews are used in narrative inquiry to uncover personal stories (Hutchinson, Wilson, & Wilson, 1994, cited in Maher, 2003).

In keeping with Clandinin and Connelly's (2000) three dimensions of narrative inquiry, I arranged interviews according to place. Participants who lived locally were interviewed first. I then travelled to the coast, a short distance of only 2–3 hours' drive, to meet with participants who did not live locally. The only exceptions were travelling to Melbourne by plane, a distance of 1250 kms for the fourth participant's interview and lastly, travelling to Sydney a distance of 475 kms by car for the last participant's interview.

In accordance with the temporal dimension of narrative inquiry, the interviews with participants took place six to ten months after the simulation experience and up to four months after the students' final clinical placements. Clinical placements occurred in a wide range of clinical contexts including regional and metropolitan hospitals, multipurpose health services, community health centres and residential aged care facilities. Also, temporally, the interviews with participants ranged from approximately 40–100 minutes in duration.

Spatially, the physical environment where interviews take place may contribute to the participant's experience and can facilitate feelings of safety and security. Participants in my research were given a choice of interview venue. By giving participants a choice over the place of interview, the researcher attempts to facilitate comfort, security and, therefore, conveys respect to the participant (Davis, 2007). The issue of place is of particular relevance to my study because the environment not only includes the interview environment but also the physical environment where simulations and debriefing occurred.

The sociality dimension ensued with looking inward and reflecting on the interviews as they took place. With the first four interviews, I found that I was not capturing the full essence of the stories on end of life simulation. Consequently, I adapted my interview technique and moved to inquire specifically about each of the five simulation scenarios throughout the course of the interview. This change in interview approach gave me a more comprehensive picture of what the entire simulation experience was like for these participants.

In an attempt to understand the social, cultural and embodied experiences of undergraduate nursing students, participants were encouraged to bring along to the interview a personal item that was meaningful to them in their experiences with end of life care. As Miller (2002, cited in Sheridan & Chamberlain, 2011) noted "Material objects enable us to extend the dimensions of talk, and their involvement in research allows us to recognize that the process

through which things gain meaning is the same process by which meaning is given to lived experience” (p. 330). In this manner, items of meaning were used as a way to live alongside participants within their experiences (Clandinin, Lessard, & Caine, 2012). Participants’ personal items brought to the interview embodied their end of life care experiences and provided a bridge across time, linking them to their past lived experiences. Individual items of meaning that stimulated looking inward and deep reflection on the sociality of end of life experiences are included within participants’ stories (Chapter Four).

3.8 Imagining a Narrative Inquiry from Field Texts to Research Texts (Field Text Analysis)

3.8.1 The Three Dimensional Space of Narrative Inquiry (Conceptual Framework)

In response to unpacking the research puzzle of understanding the undergraduate nursing students’ experiences with end of life care and end of life care simulation, the conceptual framework of narrative inquiry described by Clandinin and Connolly (2000) has guided the data analysis. This metaphorical framework (Clandinin & Huber, 2002) describes three dimensions, or commonplaces, of narrative inquiry: 1) *Temporality*: moving backward and forward between past, present and future (Clandinin & Huber, 2002) through time; 2) *Personal and social dimension (sociality)*: this dimension points inward and outward: inward towards “feelings, hopes, reactions” and outward towards “existential conditions” (Clandinin & Connelly, 2000); and 3) *Place*: the specific concrete physical boundaries of the “inquiry landscapes” (Clandinin & Connelly, 2000, p. 51).

The three commonplaces of narrative inquiry: Temporality, Sociality and Place (Clandinin & Connelly, 2000) are deeply grounded in Dewey’s (1938) notion that life is education, and are the philosophical underpinning principles of work by Clandinin and Connelly. Dewey’s work with a laboratory school (Dewey, 1938) correlates well with my research on nursing students. Dewey’s criteria of experience include three distinct criterion: 1) continuity of experience or an experiential continuum (Clandinin, 2013; Dewey, 1938); 2) interaction (Clandinin, 2013; Dewey, 1938; van der Riet, Jitsacorn, Junlapeeya, & Thursby, 2017); and 3) situation (Clandinin, 2013; Dewey, 1938).

- 1) The first criteria of experience, continuity, means that experiences grow out of other experiences (Dewey, 1938). This concept of continuity resonates with me for my research, as the study explored the participants’ experiences with end of life care prior to and after simulation (Clandinin & Connelly, 2000). There is continuity of experience as participants move back and forth through pockets of time, between the

past, the present and looking into the future across a time continuum. Furthermore, the study sought to find if continuity exists between end of life care experiences (both personal and professional), experiences with end of life care simulation and the impact of these experiences on end of life care clinical practice. Dewey (1938, p. 35) also explains, "The principle of continuity of experience means that every experience both takes up something from those which have gone before and modifies in some way the quality of those which come after". Therefore, interaction, the next criterion of experience, is also significant.

- 2) In relation to work done by Clandinin and Connelly (2000), Dewey's (1938) principle of interaction is the second overarching criteria of experience. Experiences contain an interplay of objective and internal conditions and, taken together, they form what Dewey refers to as situation (Dewey, 1938).
- 3) For the third criteria of experience, situation is inseparable from interaction (Dewey, 1938) and continuity. Within my research, the study explored the students' interactions (both personal and professional) within end of life care, across three distinct situations, or contexts, of personal, professional (clinical) and simulated end of life care situations. The study also sought to investigate their experiences as they reached forward through time and linked into future clinical practice following end of life care simulation, breaching across the liminal spaces of time and place. Etymologically, the word liminality originates from the Latin word for threshold and is used to conceptualise a state of being in between (McArtney, Broom, Kirby, Good, & Wootton, 2017), spaces in between what is and what could be (Clandinin, 2013). These liminal spaces create the time and space "to play with the possibilities not yet imagined" (Kennedy, 2001, cited in Clandinin, 2013, p. 72). In my study these liminal spaces are spaces for students to imagine future possibilities of themselves as RNs caring for patients at the end stage of life.

All three criteria intertwine and overlap, presenting narrative inquiry as a relational methodology. The criterion of continuity (time) and interaction (social) are inseparable, they intercept and unite, and different situations (environment) succeed one another (Dewey, 1938). As Dewey (1938) states "experience is always what it is because of a transaction taking place between an individual and what, at the time, constitutes his environment" (p. 43). Furthermore, the environment "is whatever conditions interact with personal desires, purposes and capacities to create the experience" (Dewey, 1938, p. 44).

3.8.2 Analysis of Field Text

Interviews were audio taped and transcribed verbatim, analysed and key threads identified. Pseudonyms were used to de-identify participants.

Using the above framework, the process of analysis of my findings involved reading and re-reading of audio and video transcripts and field texts to gain an in-depth understanding of the content of the text. Significant threads were highlighted as participants' stories unfolded. These threads unravel and intertwine and move across the three commonplaces of time, place and person. Threads in this context are defined as particular plotlines that are threaded or woven over time and place and through individual narratives (Clandinin, 2013). Narrative threads are "complex and difficult to disentangle" (Clandinin & Connelly 2000, p. 78). These threads of experience were the linking threads that weaved together the fabric and blocks of my quilt to finally form a complete quilt and piece together the research puzzle.

Using Clandinin and Connelly's (2000) framework, in analysis I looked for the following: word images that capture the participants' character; complex layers of text; binaries; metaphors; irony; competing and conflicting stories and plotlines; *temporality* where the story moves back and forward through time; contexts of *spatiality, personal and social dimensions*; repetition and recurrence (van der Riet, Dedkhard, & Srithong, 2011a, 2011b).

Metaphors in particular are important in this analysis. As Clandinin and Connolly (2000) assert, metaphors are needed to help researchers represent the wholeness of our lives and the lives of the participants we represent. Researchers, consequently, wish to represent participants as "people who were composing lives full of richness and complexity, lives with artistic and aesthetic dimensions" (Clandinin & Connolly, 2000, cited in Clandinin & Huber, 2002, p. 163).

Binaries are also significant in the analysis of field texts. In binaries, meaning is produced through juxtaposition of binary oppositions. The power through binary is seen when one term is marginalised over the other (Lee, 1992). In this sense, binaries were also sought throughout the analysis process.

Using this framework, the two phases of data collection were analysed.

- Phase One, Part One involved analysis of video recordings from the end of life phase of the simulation. Phase One, Part Two involved analysis of the simulation debriefing session.
- Phase Two involved analysis of interview transcripts. During this phase of data collection 18 participants' interviews were audio taped, transcribed verbatim and

analysed individually, identifying resonant threads of experience. Data obtained from the items brought in by participants to facilitate interview discussion were also analysed using the dimensions of narrative inquiry, especially considering the context in which the item or object is encountered (its 'external narrative') but also the meaning of the item and the meaning of the context (Banks, 2007).

The process of analysis in this instance involved listening and re-listening to audio recordings, watching and re-watching video recordings and reading and re-reading of interview transcripts. Field texts were analysed line by line to gain an in-depth understanding of the content of the text. Once familiar with the data, significant and resonant threads of meaning were identified.

Each participant's story was analysed in this manner and moving from one story to the next "checking main features, confirming previous accounts and identifying common threads and finally developing a collective story" (Holloway & Freshwater, 2007, p. 27) that unfolds in Chapter Four (Findings chapter). The final phase of analysis was synthesis of information and drawing of conclusions (Chapter Five).

3.9 Ensuring Methodological Trustworthiness

Trustworthiness is defined as the "strictness in judgement and conduct" used to ensure that steps taken in a project have been clearly set out and undertaken with attention to detail so that findings and insights "can be trusted by people with whom they resonate" (Taylor, Kermonde, & Roberts, 2007, p. 584). In this research I was concerned with how I was to ensure the trustworthiness and authenticity of participants' stories and aimed to present the multiple realities of their ontological experiences (Krefting, 1991).

Key components of trustworthiness of qualitative research include the criteria of dependability, credibility, transferability (Guba & Lincoln, 1989, cited in Koch, 2006), transparency and confirmability (Green & Thorogood, 2009; Harder, Ross, & Paul, 2013; Holloway & Freshwater, 2007).

To ensure trustworthiness of this research I used several strategies:

- 1) *Dependability*, ensuring the research process is logical, traceable and clearly documented (Tobin & Begley, 2004), was ensured through: the use of an audit/decision trail (Appendix L: Table of Threads Decision Trail) and research diary detailing research design, data collection and analysis (Holloway & Freshwater, 2007; Long & Johnson, 2000); keeping field notes (Tuckett, 2005) that facilitate

researcher reflexivity (Cuthbert & Moules, 2014); and including participants' quotes, or storied fragments in research findings (Jensen, 2008a).

- 2) *Credibility*, addresses the issue of 'fit' between participants' views and the researcher's representation of these views (Tobin & Begley, 2004). Credibility was ensured by researcher reflexivity in acknowledging my assumptions and subjectivity in relation to the phenomenon, through reflective journaling (Koch, 2006; Dowling, 2006) and maintaining field notes (Harder et al., 2013; Tuckett, 2005); through triangulation of analysis of field texts with research supervisors (Krefting, 1991); and providing faithful representation of participant experiences with storied fragments from participant transcripts (Graneheim & Lundman, 2004; Long & Johnson, 2000). For this research, participants were invited to review transcripts of the dying scene video (Scene 5), simulation debriefing and individual interview transcriptions. Students were also reminded about this option during participant interviews, however, none of the participants took the opportunity to review transcriptions.
- 3) *Transferability* refers to the extent to which findings from research apply to a wider population of participants or to different research contexts or settings (Green & Thorogood, 2009). To facilitate transferability, the context of the simulation and the research has been described in detail and through the use of a reflective journal detailing research design, data collection and analysis (Holloway & Freshwater, 2007), and participant information (demographics) (Tuckett, 2005). In this instance, the sample of students included a significant number of male students (n=5; 27% of participants) and a wide variability of ages (from 20–51 years of age) that is representative of the current general population of nursing students in Australia. However, since narrative inquiry and qualitative research in general emphasises the uniqueness of the human experience, transferability as a measure of trustworthiness is not applicable (Krefting, 1991) and "it is the readers decision whether or not the findings are transferable to another context" (Graneheim & Lundman, 2004, p. 110).
- 4) *Transparency* relates to the explicitness of the research, including honest and clear accounts of methods and procedures used in data collection and data analysis (Green & Thorogood, 2009; Jensen, 2008b). Reflexivity that involves the researcher's self-exploration and self-observation in research diaries (Hiles, 2008) including 'storied fragments' of students' verbatim accounts in the findings chapter, demonstrates that the findings are "grounded in the data" (Roberts & Priest, 2006, p. 42). An audit trail provided in researcher reflective notes outlining the context, background and feelings of the researcher also ensures transparency (Holloway & Freshwater, 2007).
- 5) *Confirmability* is concerned with establishing that the data and interpretations of the findings are clearly derived from the data (Tobin & Begley, 2004). Confirmability is

ensured through detailed field notes (Harder et al., 2013); triangulation of multiple methods, data sources and theoretical perspectives (Krefting, 1991); and reflexive journals that include events, personal reflections and awareness of the influence the researcher has on the data (Krefting, 1991).

3.10 Reflexivity

Narrative researchers are required to have a high level of reflexivity (Connelly & Clandinin, 2006). Reflexivity, considered one of the 'pillars' critical to qualitative research (Jootun, McGhee, & Marland, 2009, p.42), is defined as the "process through which a person attempts to identify and recognise external and internal influences that can affect his or her understanding of the phenomenon under investigation" (Hardy, Gregory, & Ramjeet, 2009, p. 11). Furthermore, reflexivity is "the process of examining and recording the impact of researcher and inter-subjective elements in research" (Freshwater, 2005, p. 311). Importantly, reflexivity involves the researcher's capacity to acknowledge how their own experiences and contexts inform the process and outcomes of the research (Etherington, 2004), links the person to their practice (Clandinin, 1985), and includes the effects of the researcher's personal history on the research (Anney, 2014; Krefting, 1991).

To ensure reflexivity, throughout the research and simulation process I made entries in a personal journal noting down my thoughts, feelings, frustrations and reflections. Additionally, following each participant interview, my notes focused on the three commonplaces of the narrative inquiry, paying particular attention to the sociality (interaction) and what participants' stories meant to me as a researcher, as a nurse and as a person, hearing the stories and walking alongside participants, entering into their own lives and experiences vicariously. In this manner, participants' stories are co-constructed with me as the researcher.

My journaling started at the commencement of my studies. This started with reflections on the beginning research process and how, looking forward, I dreamed how my research would start to take shape. As I reflected on my personal justification for understanding this research, my autobiographical narrative started to take shape. These autobiographical narratives, my narrative beginnings, would frequently be revisited throughout my research journey. I continued to journal throughout the course of my research, paying particular attention to my inner feelings, thoughts and perceptions of how my research was evolving and shaping. As I moved from field notes to final research texts, my reflections turned toward travelling alongside my research participants. My personal reflexivity was also facilitated through regular debriefing and consultation with supervisors, reaffirming and challenging interpretations of analysis of participants' stories of experience.

This reflexive process is an important part of narrative inquiry where the researcher's "reflections on others and themselves", become part of the research data where the researcher "becomes more than the research instrument", the researcher becomes a central part of interpretation (Hardy et al., 2009, p.11). The researcher is not separate from the research (Caine & Estefan, 2011; Krefting, 1991), and as such "we take a place in the experiences of our participants, and they take a place in ours" (Caine & Lavoie, 2011, p. 232). In this manner, the author becomes highly visible within research texts, and texts are "laced with autobiographical information" (Elliott, 2005, p. 18). This is especially significant to narrative inquiry as a relational methodology where researcher reflexivity is an integral component of the research process and is vital in addressing the relational ontological and epistemological commitments of my research.

3.11 Relational Ontological and Epistemological Commitments

Instead of using the term methodological reflexivity, narrative inquirers prefer to speak of narrative inquiry as a relational methodology (Clandinin et al., 2016). Relational ethical responsibilities are deeply intertwined throughout the research process and entail: individual ways of seeing the world (worldviews), interactions and relationships between the researcher and the participant, and power differentials amidst relationships (Park et al., 2016).

Viewing narrative inquiry as a relational methodology means that the inquirer is also under study in the inquiry. Methodological reflexivity in this instance is focused on the importance of 'self-facing' or turning the gaze toward who we are and who we are becoming throughout the study, as we travel alongside our participants (Clandinin, Caine, & Lessard, 2018; Clandinin et al., 2016; Dubnewick et al., 2018; Huber, Clandinin, & Huber, 2006). Our actions are always in relation to others and relationships are interconnected and intertwined in meaningful ways (Park et al., 2016). We become entangled in the inquiry and in participants' lives (Huber et al., 2006).

As a relational methodology, attention is shifted towards ontological and epistemological commitments fundamental to narrative inquiry (Clandinin et al., 2016; Clandinin & Murphy, 2009; Park et al., 2016). "Reflexivity in the form of autobiographical narrative inquiries comes out of the relational ontological commitments of narrative inquiry" (Dubnewick et al., 2018, p. 414). Autobiographical narrative beginnings allow us to "awaken to how we position ourselves" in relation to participants and how we frame research puzzles (Clandinin et al., 2016, p. 26). Through writing of narrative beginnings, "each of us comes to understand, to name, our research personal, practical, and social justifications" (Clandinin 2013, p. 89). My narrative beginnings began with revisiting my own first death experiences as a junior student nurse. I have done this by reflecting back on my own personal experiences and how these

have shaped and continue to shape me as to who I am becoming in relation to my research (Clandinin et al., 2016).

Burgen (1996, cited in Caine, 2010a, p.1304) using the metaphor of a path “where life begins where I am now, is always in relation to where I have been” resonates with me as I think about my narrative beginnings. I recently found myself back where my story began at the hospital where I undertook my nursing course over 30 years earlier. Walking these corridors, it occurred to me that everything is converging at this one point in time. Clandinin and Connelly’s (2000) three commonplaces of narrative inquiry: time, place and people, seem to overlap. I can almost see a former shadow of myself, a ghost of yesteryear, partially imprinted on the landscape, walking these corridors 30 years earlier, and could almost sense passing myself in these corridors. The feeling is so strong, almost spiritual; my links to this place still remain, connections reinforced through family and memories evoked through revisiting old places relevant to me as a nurse and as a person.

The experiences of researchers and participants ‘indelibly’ shape the unfolding inquiry (Clandinin & Connelly, 1989, p. 17; Huber et al., 2006, p. 212). This comment resonates with me as I think about how I shaped the simulation experience from conception of the idea of my simulated patient (Doris) through to the final performance lived out within the simulation landscapes and once again revisited during the interview stage of my research. For me this experience has changed me. Looking back, I placed myself in participants’ shoes as new inexperienced nursing students encountering clinical end of life experiences for the first time, and personally living alongside them amidst my own personal end of life experiences.

3.12 Conclusion

In this chapter, I have defined narrative inquiry relational to my research project and have provided justification (personal, social and practical) for the use of this research methodology to unpack my research puzzle and piece together the fabric and blocks of my quilt. I have also provided an outline of the research procedure and an overview of the simulation procedures; recruitment and sampling procedures and the two phases of data collection and analysis in relation to the narrative inquiry conceptual framework of Clandinin and Connelly (2000) underpinned by Dewey (1938). In this chapter, I have also addressed methodological trustworthiness, and the role of researcher reflexivity, and considered the relational ontological and epistemological commitments of narrative inquiry.

In Chapter Four (Findings chapter) significant threads of students’ experiences with end of life care and end of life care simulation are revealed through analysis of field texts. In this chapter, the threads of experiences become intertwined and interlink through and across

other students, pull together and bind the fabric and quilt blocks that start to form the final quilt, and piece together the research puzzle.

Chapter Four: Findings

4.1 Introduction

In this chapter, I present individual participant stories of end of life care and end of life care simulation as I travel alongside participants, sharing their stories. Stories evolve and unfold through co-constructed storied fragments revealed through the simulation landscape of the dying scene, the debriefing landscape and the interview landscape. These landscapes intertwine amidst individual participant stories to form significant resonant threads that unravel and re-intertwine across other participant stories. Sometimes, stories bump up against others, causing tensions, sometimes finding resolution, and at other times leaving a void looking into the future as forward looking stories.

Clandinin and Connelly's (2000) narrative inquiry framework and Dewey's (1938) criteria of experience both underpin the analysis of my research findings. All three commonplaces of Clandinin and Connelly's (2000) framework for narrative inquiry intertwine throughout. For example, participants' stories are told individually in chronological order as I undertook the interviews and are presented in this order to be consistent with the dimension of temporality. Relationships between the researcher and participants are at the heart of narrative inquiry as we work alongside each other in relational ways (Clandinin, Caine, & Steeves, 2013). In this manner, sociality (inner and outer feelings) is revealed through the social processes involved as the stories unfolded. Interviews took place in various landscapes (spatiality) that were co-negotiated to meet individual needs. In attending to the places our stories have unfolded (Clandinin, 2013), we are shaping the storied landscapes and co-composing research texts.

As narrative inquiry is a relational methodology, I, as the researcher, am aware of where the participants and I are placed at any particular moment in time, spatially, and within personal and social contexts (Clandinin & Connelly, 2000). Temporality is further intertwined in this chapter with stories of experience unfolding over three distinct time frames, told across a time continuum. These included students' background stories of experiences (both personal and professional) with end of life pre-simulation. Participants' background stories, their past experiences, are especially important and relate to Dewey's (1938) criterion of continuity (answering the first research aim). Students' end of life care simulation stories are then told to gain an understanding of the meaning these experiences had for them (addressing the second research aim). As stories of simulation unfold, the impact of simulation intertwines with simulation experiences as they emerge. This is seen where some participants contemplate their future clinical practice, looking ahead as RNs into the future (answering the third research aim). In this study, the criterion of continuity reveals important links with

past, present and future end of life care experiences. There are moments in time that intertwine and interconnect throughout the participants' stories.

Within each participant's stories, dominant and resonant threads relevant to the research puzzle are revealed and explored in-depth, in this chapter. These threads (summarised in Appendix M: Table of Threads) are: Thread 1: The role of others in shaping death experiences; Thread 2: Attending to family at the end of life; Thread 3: Theory, practice and experience become synergised; Thread 4: Managing self amidst negotiating difficult conversations at the end of life; Thread 5: Managing self amidst unfamiliar landscapes of death and dying; Thread 6: Defining moments in time; Thread 7: Real versus unreal landscapes in simulation; Thread 8: Finding comfort amidst learning and working together.

Threads unwind, intertwine and tangle as they come together to form a metaphorical quilt, woven from different fabrics that weave together to tell a story of experiences with end of life care and end of life care simulation. For each participant, a quilt block is formed by various threads; these threads intertwine, interlink, interweave, entangle and bind together with other participants across simulation, personal and professional (clinical), and the shared social university landscapes. These intertwining threads are brought forward at the end of each participant's stories to illustrate how this metaphorical quilt is joined together (Appendix N: Metaphorical Quilt).

4.2 Meeting Holly

Holly was the first of my participant interviews, undertaken in my office, six and a half months after the simulation. Holly is one of those students who gives 100% to everything she undertakes. I was not surprised when she volunteered to participate in my research. Like me, Holly (aged 21 at the time of the simulation experience) came to her nursing degree as a newly graduated high school student. Holly had also worked part time as an AIN for the past 12 months while completing her nursing degree and I was proud to have known this softly spoken, intelligent and unassuming young woman, who was willing to share her stories of her experiences with me.

Catching up with Holly for the interview, I felt anxious and excited, my feelings were ambiguous and filled with tension. I was excited about moving into the next phase of my research and the final phase of my gathering field texts, however, I was also anxious with anticipation about how this first interview would go. In negotiating our venue for the interview, we both agreed to meet in my office. Although at the time I did not see this as a barrier to the interview process, I now wonder whether this has added to my own anxiety leading up to the

interview, as this is a place where I am expected to perform and achieve my goals at a high level.

When I caught up with Holly, she appeared relaxed and comfortable, welcoming me with her beautiful smile. Holly was very generous in sharing her experiences and I was soon to discover how closely embedded her personal experiences with death and dying were to become for her. Holly's storied fragments of end of life care began a long time before both her nursing experiences and the simulation experience.

4.2.1 Holly's Background Story

Holly's background story, of her end of life experiences prior to her simulation experiences, begins with her first experience with the death of her grandfather when she was 14 years old, and how this impacted on her life and chosen career of nursing. Through this very personal experience Holly has come to see death as beautiful. Holly's background story intertwines throughout her simulation stories where reverberations of her first death experience and perception that death can be beautiful are seen throughout. This previous experience of Holly's resonates with Dewey's (1938) philosophy and criteria of experience intertwining interaction, situation and especially continuity where the past, present and future align across a linear time continuum.

4.2.1.1 Thread 1: The role of others in shaping death experiences (death can be beautiful)

During her participant interview, Holly compares personal experiences with her first clinical end of life care experience during the first year of her nursing degree on the hospital ward in a small rural town. Holly found that the role of others, in this case the supportive nurses, helps in making experiences with end of life positive. Using positive language, she found that death can be beautiful, and that witnessing death is a privilege:

I liked the way that they [the nurses] looked after him ... and they were really amazing with the family ... just really **respectful**, and looked at the patient holistically ... which is **beautiful** ... it ended up being a good death ... (p. 8) ... [the nurses] cried with the family (p. 9) ... [were] really empathetic and ... **compassionate** and shared that emotion with them ... and they [the nurses] were really **respectful** with the body after death as well ... even talking to him ... and just keeping his dignity when they were washing him (p. 10) ... I wasn't worried about it because I had had experiences before then, so nothing could really compare to that (p. 14) ... I thought I would have been more emotional, but I wasn't (p. 17) ... I see being by someone's bedside as they're

passing away just as much of a privilege as being there at the birth ... **death can be a really beautiful thing** (p. 18) ... I feel really heartless ... it didn't make me feel upset, I just thought, "**Oh, that is really beautiful**" (p. 19)

Although Holly describes death as beautiful, there is a paradox here that causes tension. At the same time, Holly felt 'heartless' because she did not feel upset by this experience but instead, thought this was a beautiful experience. Clinical end of life care experiences such as this have become part of Holly's experience and how she has embraced death and dying. Holly's description overlaps interaction, situation and continuity. In comparing the binary of birth and death, Holly does not privilege one over the other. Witnessing death is seen as just as much a privilege as witnessing birth, both are seen as beautiful moments intertwined in time. Holly's experience is shaped by the presence of others and, in this instance, it is the nurses who shaped this experience. The compassionate, respectful, empathetic and holistic care provided by the nurses to the patient and family helped shape this beautiful experience for Holly. As Holly's and other participants' stories unfold, 'others' who shape these experiences are not only nurses, but also sometimes include patients, family or other people involved at the end of life.

Interlinking her clinical experience above with her own personal experience with her grandfather's death, Holly found that nothing could compare to this experience. In this next excerpt taken from Holly's interview, she reflects back to her own positive personal experience as she sat with her mother watching her grandfather dying in hospital, when she was a teenager.

Mum ... said "It's ok, you don't need to be scared (p. 30) ... come and sit by his side and talk to him and just watch the process ... it's not scary" ... when he eventually passed away ... I realised it wasn't as bad as what you expect, as shown in the movies ... the media's got a big part to play (p. 32) ... and as soon as he drew – you know how they draw their last breath – mum said, "Just watch" ... and **it was just beautiful**. (p. 33)

Looking inward, exploring feelings and reliving this very personal experience, Holly remembers her grandfather's death as "beautiful". Holly recalls sharing this experience with her mother and how her mother helped make this experience beautiful, talking through her grandfather's death and living this alongside her. Consequently, Holly found that witnessing death was not as bad as what she had expected. She juxtaposes how the media portray death and dying in movies, with her own beautiful experiences with death and dying. Continuity, interaction and situation intertwine throughout Holly's story.

During her interview, Holly produced her item of meaning in the shape of a small decorative ornamental butterfly, further interlinking her personal experience with her clinical experiences

with end of life care. Holly's beautiful experience continues when talking about her item, saying:

My pop gave it to me before he passed away ... [softly laughing] ... **I keep it with me all the time** (p. 37) ... a little butterfly like ornament ... it just reminds me of that time ... **reminds me of him** ... I think about him all the time ... [quietly crying]. (p. 38)

Holly, laughing softly whilst reliving her memories of her grandfather, starts to quietly cry, signifying that her small quiet laughs were perhaps an attempt to stop herself from crying. Holly's experience with the death of her grandfather is further intertwined with her item of meaning, which provides a link to this beautiful death experience and has become a conduit not only of Holly's memories, interlinking past with present, but also of her strong emotions. Touching the item gently and looking at this with fondness provides a joyful reminder of her 'Pop' and being by his bedside during his moment of death. Thinking about Holly's small item of meaning, I can't help but feel that this item symbolises much more than Holly's link back to her grandfather; it may also play a role that further signifies death as beautiful. Perhaps this is why she chose to share this item with me.

Comparing my own experiences with Holly's, I remember my first clinical experience with end of life care as a young first year student nurse, at a similar age to Holly, feeling numb and unsure of how I should feel. But, unlike Holly, my own feelings were intermingled with fear, distress and sorrow. In contrast to Holly, during my first experiences I came to see the ugliness of death and it wasn't until many years later as a mature and experienced registered nurse that my perceptions changed, finally resolving the tension within myself, that death can also be a beautiful thing.

Moving forward in time to Holly's experiences with end of life care simulation, it becomes evident how her background stories of her grandfather's death and her first clinical experiences with end of life care have shaped her as a nurse and are reflected in how she reacts and responds during the simulation during the dying scene.

4.2.2 Holly's Simulation Story

4.2.2.1 Thread 2: Attending to family at the end of life

The second key thread for Holly centres around attending to family at the end of life. This is seen firstly, in how Holly attends to family during the simulation.

Holly's simulation experience began with the nausea and vomiting scene. Moving forward to the dying scene, playing the role of the RN, Holly talks the family (David and Grace) through the dying process:

... "Doris, it's Holly here, I'm the nurse on the shift today, just going to have a look how you're going" (End of life scene, p. 2) ... so, what's happening now is that she's [Doris – manikin] ... **just taking her last breaths now** and, once Doris has died, "We will just leave you [David and Grace] with this time to say goodbye to her [Doris] ... I encourage you to hold her and just talk to her". (p. 4)

Intertwining what she has learnt from others, Holly normalises death and reassures the family about the normal processes of dying. Continuity across three moments of time surrounding death are reflected in Holly's storyline (before, during and after death). Her own personal experiences with the death of her grandfather and her beautiful clinical experiences have travelled alongside her and shaped her simulation experiences. This learning from previous experiences is seen in how Holly talks through the dying process and attends to the family during simulation, very much like her own mother talked through the death of her grandfather.

4.2.2.2 Thread 3: Theory, practice and experience become synergised

For Holly, the simulation has almost worked like a conduit, linking her simulation experience with her personal experience, where theory, practice and experience become synergised and intertwined:

They are really frequent things that you see ... and **I felt more confident** ... more educated by the end ... using the simulation to put all of the **theory into practice** is really good (p. 3) ... **I really liked the debriefing** ... you can just have everyone's opinion (p. 4) ... and everyone looks at it from a different approach as well, everyone's had their own experiences ... so to get other people's perspectives who have actually been through it ... I have had a close family member pass away and I was there by the bedside ... it brought back a lot of those memories (p. 5) ... so, to look at it from a nurse's perspective was good ... I could think back to then and think "Oh, that's why they might have done this". (p. 6)

Holly found that the simulation debriefing was important because this brought together everyone else's experiences, not only of the simulation but also of experiences with end of life care in the clinical context. Importantly, she found that the simulation brought together theory and practice, linking these to clinical practice. Thinking back in time, Holly found the simulation was powerful in helping her recall past memories about her experience of death

and dying when her grandfather died. The debriefing spaces in the simulation provided room for reflection and interaction.

Although Holly has not had many end of life care experiences following the simulation, she is able to reflect on learning that occurred from simulation and how she has applied the learning from simulation to clinical practice:

The symptoms were very similar ... just having that **knowledge from the simulation** (p. 26) ... I could think back to the visual kind of things ... like I recognised it ... from the sim [simulation] ... because we had addressed that in such a practical way ... **you kind of look for those things now.** (p. 27)

Linking her clinical experiences with the simulation, Holly is able to compare her experiences of end of life care. Gaining knowledge from simulation, for example on symptom management, allowed her to remember and recognise what she had learned from the simulation. Following the simulation, and looking to the future, Holly now looks out for those things in clinical practice, and I wonder whether when she does find these in clinical practice whether she will think back to her simulation experience.

4.2.3 Holly's Intertwining Threads

Holly's story encompassed three resonant threads of significance. Holly has come to see death as being beautiful because of the role of others (Thread 1). Her experiences have given her the ability and confidence to walk alongside the person and family through the death experience (Thread 2). Learning through simulation, she found that theory, practice and experience have become synergised (Thread 3). Thread 3 is the intertwining thread that links Holly to Noah.

4.3 Introducing Noah

Noah was the second participant interviewed, one week after Holly, and six months and three weeks after the simulation experience. I first met Noah the year before the simulation, in his first unit of study at the university. Noah, a newly registered nurse in his own country, had recently moved to Australia from the Philippines to undertake a Masters of Nursing Practice Degree, the only student in my research undertaking this degree. Although Noah was already a registered nurse in his own country, he had minimal nursing experience, instead, working as a nursing educator at a local university in the Philippines.

Noah, aged 28 was a quietly spoken, shy and very respectful young man. We decided that we would meet in the nursing clinical laboratories for his interview, a venue convenient to both Noah and myself, since Noah had taken some casual work in the nursing clinical laboratories, as a laboratory assistant. This setting was found to be fitting since these were the same spaces used in the simulation sessions; a space we were both familiar with in our roles as lecturer and laboratory assistant. Although the clinical laboratories were open and warm in the afternoon sun, the room quickly became dull as a late spring afternoon storm filtered in, with noise of the storm intruding on the latter half of our interview. Despite this, we managed to finish with little interruption.

4.3.1 Noah's Background Story

Noah was the only international student to undertake my research. Coming from a very different culture, the Philippines, Noah's storyline centres around the differences in end of life care in his home country, his inexperience and his cultural background. At the time of the interview, Noah had been in Australia for only two years. His background story did not include any end of life care experiences prior to the simulation and had included only one after death care experience as a new graduate nurse in the Philippines. In the Philippines, unlike in Australia, end of life care is the role of the doctor. This is significant for Noah entering into the simulation with limited clinical experience with end of life care.

4.3.2 Noah's Simulation Story

Although Noah was present during the simulation debriefing, his voice was quiet throughout. It was not until the interview that I was able to gain a clear picture of Noah's experiences during the simulation. For Noah, his main storied fragments of simulation are deeply embedded within his cultural experiences. Additionally, learning from his peers during simulation created anxiety and tension for him as he negotiated difficult conversations.

4.3.2.1 Thread 4: Managing self amidst negotiating difficult conversations at the end of life

Noah's simulation experiences with end of life care are different to his previous experiences in his home country. In the simulation Noah is, for the first time, confronted with difficult conversations at the end of life during the nausea and vomiting scene:

[In the Philippines] we never had experiences like that ... not actual patients, so it **was a bit confronting** ... I've never been in situations where the patient's actually

dying ... or asks “Am I dying?”. I actually prepared and ‘googled’ what to say ... because **I didn’t know what to say** ... I actually said what the script [said] (p. 5) ... and they [other participants] were saying “You actually said the right thing but you need more emotion”. (p. 6)

The sociality of care at the end of life and how this is treated differently in his own culture resonates throughout Noah’s discourse. Due to his uncertainty, he prepared himself by researching typical responses at the end of life. Although Noah found the right words in response to these difficult questions, Noah has learned that he needed to show some emotion and deliver his response with sensitivity.

4.3.2.2 Thread 3: Theory, practice and experience become synergised

Noah’s simulation story starts with the constipation scenario and his experiences unfolded as the scenes progressed. Playing the role of the RN during the pain scenario, the last scenario of his simulation experience, in this storied fragment, Noah explains some valuable lessons from the simulation:

I realised that during the **debriefing** ... **I will forever take the knowledge with me** (pp. 13–14) ... the lesson I learned was just to make the patient comfortable first ... before peppering them with questions ... that’s the biggest thing I had with the sim [simulation] ... make them comfortable first. (pp. 32–33)

The sociality of simulation is again dominant for Noah as he talks about learning from the simulation, where theory, practice and experience become synergised. The simulation debriefing was instrumental in consolidating Noah’s learning. Noah’s learning that he will take with him into the future was making the patient comfortable and for Noah, this was one of the biggest impacts of the simulation. As I continue to think about Noah and his end of life care experiences, I am left wondering what kinds of experiences are in store for him. Because of his history with nursing education in the Philippines and his role in the nursing labs, perhaps if he remains in nursing education, these may be simulated end of life care rather than clinical end of life care.

4.3.3 Noah’s Intertwining Threads

Noah’s central threads revolve around managing himself amidst negotiating difficult conversations at the end of life (Thread 4), and learning from his peers in simulation, synergising theory, practice and experience (Thread 3). These two threads intertwine and bind together Noah and Luke.

4.4 Getting to Know Luke

Luke (aged 22) was the third participant to be interviewed and, like Holly, Luke's interview took place in my office, six months and three weeks after the simulation experience, on the same day as Noah's interview. I had also known Luke since the beginning of his undergraduate degree, two years' prior to the simulation. Like Holly and myself, Luke was a teenager when he began his nursing degree, entering into his degree after having a gap year on completing his Higher School Certificate.

Entering the simulation, Luke had been working as an enrolled nurse (EN) for the past six months, gaining experience in a local healthcare facility while he completed his nursing degree. During Luke's time at university, I came to know him as an intelligent, very confident and competent young man. This was particularly evident in how he responded to questions during the participant interview, in an open and friendly manner, not only being generous with his time, but also showing generosity in sharing his experiences.

4.4.1 Luke's Background Story

Luke's background story transverses across several years, beginning with the personal experience of the death of his grandmother, when he was a teenager, and continues on to intersect with his clinical and simulation experiences.

4.4.1.1 Thread 1: The role of others in shaping death experiences (negative personal experiences versus positive peaceful deaths)

Luke's first personal death experience was seeing his grandmother die when he was in his final year at high school. Unlike Holly's 'beautiful' experience, Luke's was a negative experience shaped by others:

The most **negative experience** was with my grandma ... during Year 12 ... I didn't have the knowledge that I have [now] ... and I just wish I knew what I know now ... it was quite a **horrible experience** (pp. 16–17) ... I was angry and the most challenging thing is working at the hospital, I still see those nurses ... it just makes you feel kind of hopeless now that you think you could have done so much ... (pp. 17–18) ... kind of makes you angry ... there was never really palliation steps put into place, it ... was quite undignified ... it's just hard to see someone you love dying. (p. 18)

Luke's first experience with death was one surrounded by pain. This experience was made difficult for Luke because he found the role the nurses played in the care of his grandmother was undignified. In retrospect and bridging gaps across time and across spaces, Luke, now

knowing about palliative care and end of life care through simulation, is able to perceive how much better this experience could have been for his grandmother. Luke's feelings of anger and hopelessness reverberate throughout his discourse, reinforced by repetition of the word "angry". His anger has travelled with him across time, his experience a strong contrast with Holly's first beautiful experience with her grandfather's death.

Luke's thoughts and feelings are sliding back and forth across time and over different landscapes, intertwining among interactions. Landscapes of the clinical ward where his grandmother died, the landscape of the clinical simulation laboratories and the landscape of his current workplace are all reminders of his grandmother's death, a death that could have been much better for her and her family.

Moving ahead in time, Luke reflects on his first clinical experiences with end of life care, prior to the simulation. It was not until the second year of his degree that Luke experienced his first death in clinical placement:

In HDU [High Dependency Unit], there was a gentleman palliated and ... it was a **really peaceful death** for him [the patient] ... he passed away with his family there (p. 18) ... we [my nurse and I] went in and just had this discussion with the family on kind of, the next steps. (p. 19).

In contrast to Luke's previous difficult experience with his grandmother's death, he was fortunate to experience a peaceful death with his first clinical experience of death. Although there was tension for Luke with the death of his grandmother, this is smoothed out as he experiences a peaceful death on clinical placement. Luke's experience was shaped by the nurse who took the time to go through the processes of dying with him and the family. This peaceful death experience also gave Luke some insight into the processes of having difficult conversations at the end of life. These processes he was then able to carry forward to apply during his simulation experiences and beyond.

4.4.1.2 Thread 4: Managing self amidst negotiating difficult conversations at the end of life

In this thread, Luke reflects back across time to a personal experience of the death of a friend's sister after he finished high school and not knowing what to say or how to comfort his friend:

In my gap year, my best friend's sister [Melissa] suicided and ... the hardest thing was like, you have such a good relationship and all of a sudden you can't talk because **you just don't know what to say** ... like you can't really apologise for it ...

I just remember just completely shutting off and **thinking what can you say** (p.19)
... that was a hard thing to deal with. (p. 20)

Item of meaning: I didn't know how meaningful it would be but, I carry round with me always [bright pink ribbon] ... and that's from Melissa's funeral ... we all wore ribbons on the day so that's in my wallet all the time now. (p. 20)

The feelings that Luke expresses here are very common feelings experienced when someone close to us experiences the sudden death of a loved one. We feel we need to say something but are lost with what to say. When my sister-in-law recently experienced the death of her teenaged son under violent circumstances I also experienced a loss of what to say to her. These feelings of pain, loss and not knowing what to say are overwhelming. In experiencing these feelings, I also feel a close association and empathy with how Luke must have experienced this when his friend's sister died all those years ago.

Luke's personal item of meaning provides a conduit to his feelings, bridging across time and across landscapes; with the aid of this tangible item, he is able to look backwards in time to Melissa's funeral, recalling not knowing what to say. This not knowing what to say resurfaces when Luke is confronted with difficult conversations during the end of life care simulation.

4.4.2 Luke's Simulation Story

For Luke, his central simulation storyline is about being in the midst of difficult conversations and not knowing what to say. This has been such a dominant thread throughout his key storylines, commencing pre-simulation with personal experiences with grieving, carried forward in time to the simulation, where he takes on the responsibility of having difficult conversations in one of the simulation scenarios. Finally, his experiences have closed the circle of experiences with him managing difficult conversations in clinical practice.

4.4.2.1 Thread 4: Managing self amidst negotiating difficult conversations at the end of life (taking on responsibility)

Luke's primary simulation storyline centres around attending to the difficult questions and negotiating difficult conversations at the end of life. Although Luke's simulation experience began with the constipation scene, looking back over Luke's interview, the most memorable scene for him was the unconscious patient. For Luke, playing the role of the RN alongside Simon, managing himself amidst difficult conversations involved taking on the responsibility of addressing difficult questions asked as the scene unfolded:

That was the hardest one ... **taking on the responsibility** to tell the son that his mother was dying ... [the son] asking a lot of pressing questions ... as soon as he said “Is my mum dying?” ... I was like “Is this, like, my place to kind of step in and say?” ... I even stopped for a second and exhaled and thought “... just be as honest as possible” ... He responded well to that so it made me feel a bit more comfortable. I still think you could answer those questions so much better, but ... when you are put on the spot. (pp. 3–4)

This scene had the biggest impact on Luke and the one he found to be the hardest; playing the role of the RN it was his role to respond to the difficult questions and to take on these difficult conversations at the end of life. Luke’s feelings come full circle, after firstly, not knowing what to say and finally, juxtaposing his feelings in gaining confidence by the end of the scenario. This is a poignant experience for Luke, evident when he talks of his embodied practice of exhaling and thinking. Luke uses these strategies to buy himself some time while being confronted with negotiating these difficult conversations. For Luke, time actually stands still while he gathers his thoughts, thinking about the best way to approach this difficult topic. Looking ahead, I wonder what responsibilities Luke will take on in his clinical practice as an RN in the near future.

4.4.2.2 Thread 3: Theory, practice and experience become synergised

During his interview, Luke is able to relate how the simulation has impacted on his clinical practice and how simulation helped in preparation for communicating under difficult circumstances synergising theory, practice and experience:

Since then [the simulation], I’ve had conversations with elderly patients and that sort of thing has come up, end of life decisions ... sitting down with them and going through what they wanted. (p. 2)

For Luke, taking his experiences from the simulation into clinical practice, he found that the simulation experience has helped him with communication and increased his confidence in managing conversations about end of life.

In this next storied fragment, Luke shows how theory and simulation are synergised into clinical practice:

That definitely **helped me with my communication** ... at that stage (p. 10) ... [the simulation] highlighted the responses that you might have when speaking with the

family ... that whole honesty and openness with the family ... that helps a lot when family are asking "What's going on?" (p. 15)

Luke's comments reflect how much he learned from telling the son bad news in the simulation then integrating this within his clinical practice. The impact of simulation in this instance reaches across social and professional clinical landscapes where Luke is able to confidently raise these concerns with others.

4.4.3 Luke's Intertwining Threads

Luke's first painful experience with his grandmother's death reveals the impact that others can have in shaping experiences (Thread 1). His simulation experiences have given him the confidence to manage difficult conversations at the end of life (Thread 4), synergising his experiences with theory, practice and experience (Thread 3). It is all three of Luke's threads that interweave his experiences with those of Renee.

4.5 Introducing Renee

Unlike the previous participants, Renee was one of the few participants who I did not know prior to my research. Renee, aged in her late 30s, had been an EN for 10 years and had been a police officer prior to doing her EN training. Renee's rich experiences that she shared included some traumatic deaths that she witnessed as a police officer.

I did not meet Renee until the day of the simulation session when she approached me and introduced herself prior the simulation pre-brief. On meeting Renee for the first time, I was struck by her warmth and professionalism. Our first meeting was a brief one because of the time constraints of the simulation. However, I did get to know her a little during the simulation dying scene where she undertook the role of the RN and, in this scene, she drew on her vast experiences with life and as an EN.

Our interview was arranged for six months and three weeks after the simulation, meeting in the lobby of the hotel where I was staying, in Melbourne. I was pleasantly surprised by Renee's open nature, welcoming me with open arms, giving me a gentle hug as if we were old friends. This immediately put me at ease and set the scene for a wonderful interview, full of rich stories and shared emotion as we relived her many experiences. I found interviewing Renee to be a beautiful experience, even despite the noises and disruptions of the surroundings in the small bar area of the hotel. Renee was very sincere and generous in sharing her experiences with me, of rich and vivid memories of some extraordinary

experiences. I feel very privileged to have become part of her story and perhaps her inspiration for her future career and her future desire to become a palliative care nurse.

4.5.1 Renee's Background Story

Renee's dominant background stories are about her previous experiences with death as a young police officer prior to studying nursing. During this time, Renee was involved in many traumatic deaths that had a big impact on her life and eventually led her into nursing and her passion for palliative care (as well as her interest in participating in my research). Her experiences with death are also closely interwoven with her chosen item of meaning, a St Christopher's medal/signet ring that she bought in Armidale, NSW while on her first clinical placement during the second year of her degree. For Renee, this ring reminds her of her own mortality and became a symbol of her desire for protection and safety:

The main thing I wear all the time is my St Christopher [ring] because ... I have done so much travel ... in the last two years ... the realisation of **my own mortality** kicked in ... **St Christopher** is the patron saint of travel and he protects travellers ... it is just a good luck charm ... I don't leave the house without it ... **I am aware of my own mortality now**, I am not scared of it either ... that **reminds me of my mortality** and how careful I have to be. (pp. 22–23)

Renee's item of meaning symbolises for her a very real reminder of her own mortality, and this is reinforced with the repetition of the word "mortality". As a police officer, she has been a witness to many deaths during her life. Symbolically, she wears this ring on her wedding ring finger and I am left wondering about her relationship to this ring and her own mortality. The ring interlinks across a continuum of time and situation. Symbolically, St Christopher already plays an important role in Renee's life: the patron saint's presence is socially embedded within her stories to live by.

Not long after my interview with Renee, I found a small St Christopher's medallion, given to me by my uncle over 26 years ago, kept in my suitcase that travels with me wherever I go. I had forgotten all about this little medallion and was pleasantly surprised when I found it recently. Finding this, I immediately thought of Renee and her personal item of meaning – this small item, interconnecting me with Renee and forming a bridge across us, as we co-construct these research texts. I think of some of Renee's experiences with death and find myself reflecting on how similar some of my own experiences with death are.

4.5.1.1 Thread 5: Managing self amidst an unfamiliar landscape of death and dying

As a young police officer, Renee experienced many traumatic deaths. Although she has had many experiences, they were varied and each has affected her in different ways, causing her to manage herself in different ways amidst these unfamiliar landscapes of death and dying:

I came in to see the Myer [department store] windows [Christmas shopping] ... I saw the guy jump out of the window during the Queen Street massacre [Melbourne] ... I was a bit scared of doing my nursing because I used to think maybe I am the angel of death or something. I had this real phobia ... joining the police force helped me ... deal with that very quickly because ... death happens so much but it is part of life ... **it doesn't not affect me emotionally** but I can see what I need to do now, I am able to look at the bigger picture now ... I can deliver more holistic care now, because I am not so confronted by the reality ... I have had a lot of experience ... it strengthened me and ... I know now what I want to do with my life, it sort of brings you in this circle ... I think by the time you have life experience ... you can then turn around and say "This is really what I want to do with my life". (pp. 13–14)

... as part of my police training ... elderly people getting hit by cars, things like that ... when you are directing traffic, I have learnt to block it out. (p. 22)

For Renee, many of her first death experiences were unfamiliar experiences for her. Renee has been able to use these experiences in a positive way and has found that these experiences have shaped her. She is aware that death is a natural part of life and feels she has learnt how to deal with death by blocking it out. I am left wondering what Renee actually means when she says that she has learnt to block death out. Her comment bumps up against what she said previously. On one hand, her response is positive as she feels death has strengthened her and made her realise what she wants to do with her life. However, on the other hand, she feels that she had learnt to block it out. Perhaps this immediate reaction of blocking death out was/is for her a way of coping with traumatic death. There is a hint of tension here, with some resolution as she feels that she has come full circle. Her experiences give her the ability to see the bigger picture of life, and enable her to deliver more holistic care. Her use of language here is also revealing, as she uses the double negative "it doesn't not affect me emotionally". In the use of the double negative, she is saying that death does affect her, but through her previous experiences she has developed resilience and coping mechanisms to deal with such situations. Not only are her words significant but also the passion she felt/feels is evident in her use of body language, leaning forward throughout the interview and saying this with meaning.

4.5.1.2 Thread 1: The role of others in shaping death experiences (beautiful)

Contrasting with her difficult experiences as a young police officer, Renee experienced a very different kind of death whilst on her third year community palliative care clinical placement prior to the simulation. Renee's beautiful experience below echoes Holly's beautiful first experiences with death, but both are in stark contrast with Luke's personal experience. Unlike Holly's experiences which are shaped by the nurses and her mother, Renee's are shaped by the patient's family:

It was just the most **fantastic experience** I have ever, ever had. **I loved it** ... what hit me the most was that a lot of the palliative care patients were so young ... my expectation was that being an EN ... I had this picture of this lovely old person dying that it is going to be (p. 10) peaceful and was going to be lovely and not distressing for the family ... and I walked in to a situation with a 53-year-old guy ... and they were just such a beautiful young couple and I thought "This is just awful, what's happened to them?" (p. 11) ... the age factor was **very confronting**, and being in someone's home and seeing photos of what they looked like prior to becoming ill and then seeing the person in front of you, it is [a] totally different person, that was very **confronting** ... She wanted to ... hold hands as they went to sleep ... it was just **really, really confronting**, it was very real ... it was **just beautiful**, she just didn't want to let him go. (p. 11)

For Renee, others who helped shape her end of life experiences are the patient and his partner. Describing many emotions, it is easy to understand the passion that she developed for palliative care over such a short period of time. However, there is tension and ambiguity within Renee's storied fragments, as her stories bump up against each other. In one, she describes being confronted by the age of the young couple, but in another her experience of death is also very beautiful, bearing witness to a special relationship of a couple not wanting to let go of each other. The private landscape of this couple's home makes this even more confronting for Renee. Here she views photographs of the young couple that have gives Renee a glimpse into a previous life that was carefree and illness free, a stark contrast to what Renee sees in the present moment. The photos link past to the present, the disrupted images of a previous life contrasting sharply with reality in the present, of a life disembodied by disease, an altered body ravaged by cancer and impending death. Renee feels embraced by this couple, sharing their journey with them and shaping her experience into a beautiful, but nevertheless painful experience.

This experience has stayed with Renee and further formed and shaped her experiences which have evolved from difficult traumatic death experiences, where she coped by blocking these out, to finally embracing good death experiences where she could become part of the family's journey.

Renee's background stories form her experiences and shape what she brings with her into the simulation and are a precursor to her simulation experiences.

4.5.2 Renee's Simulation Story

4.5.2.1 Thread 7: Real versus unreal landscapes in simulation

Renee's simulation story begins with the dying scene. During this scene, playing the RN with Sarah, Renee finds that students playing roles of family members impact on the real versus unreal landscapes of the simulation experience:

The other scenes were easier because most of them were real actors. The last one was more difficult because it was **a dummy** ... I didn't feel as emotionally attached ... as I did to the family member sitting beside her ... I was more focused on the person that was the **real person** (p. 7) ... it was just not that **flesh-to-flesh experience** ([with a manikin] ... [having fellow students in that role] that felt great. (p. 8)

Looking inward, Renee felt an attachment to family members sitting by the patient's bedside, suggesting realism within the scenario. She was more focused on the real person, and found the flesh-to-flesh embodied experience to be important. Renee's comments reflect the importance of having real people in simulation enabling an emotional attachment and forming a connection. Renee's words resonate with her actions during the dying scene, while playing the role of the RN, she gently reaches out and touches her colleague, further embodying this 'flesh-to-flesh' experience.

4.5.2.2 Thread 6: Defining moments in time (looking to the future)

Renee talks about how the simulation experience brought her experiences together and confirmed for her, a strong desire to become a palliative care nurse in her future career.

It was just ... one of the **defining moments** that I knew that I wanted to do palliative care ... it just felt really, really good ... I really enjoyed it so that was **the defining moment**, I suppose. (p. 25)

Renee's experiences in the simulation are very personal and very social for her, as she realises her passion for palliative care. I find myself wondering whether Renee will one day become a palliative care nurse and whether she will think back to her simulation experience. For Renee the simulation provided a medium for her to consolidate her experiences and looking ahead has helped define her future career aspirations. Her story comes full circle

from traumatic end of life experiences as a young police officer to her beautiful clinical experiences with community palliative care.

4.5.3 Renee's Intertwining Threads

Renee's stories of end of life care and end of life care simulation are across multiple threads, including: managing herself amidst unfamiliar landscapes of death and dying (Thread 5); patients and family shaping end of life care into a beautiful experience (Thread 1); an embodied flesh-to-flesh experience amidst real versus unreal landscapes in simulation (Thread 7); and finally, in defining moments in time which enable her to look ahead to her future nursing practice (Thread 6). There are two threads that interweave and intersect with Louise (Threads 1 and 5).

4.6 Meeting Louise

Louise (aged 20) was a very quiet and reserved person and, because of her shy nature, I was surprised when she volunteered to participate in my research. I had known Louise since first year in her first semester of study. Although she was always attentive in class she was very quiet and rarely volunteered to participate openly in class discussion, often keeping her opinions and ideas to herself. Upon entering the simulation, Louise had been an AIN for approximately four years.

Our interview took place in a café located close to where Louise lived in a small rural town. I had driven to meet with Louise at her home town, an hour and a half away. On the drive up to meet with Louise and knowing her as a shy and reserved person, I found myself wondering what Louise might have to say and add to my research. The interview with Louise was on a warm December day, seven months after the simulation experience. Our interview lasted around 40 minutes. Although Louise was keen to participate in my research, interviewing her was challenging due to her shy and quiet nature.

4.6.1 Louise's Background Story

4.6.1.1 Thread 1: The role of others in shaping death experiences

Although Louise had not actually witnessed someone dying in clinical practice before the simulation experience, she had provided care after death. She was 16 years old and undertaking a school apprenticeship as an AIN when she saw her first deceased person:

That was a bit **confronting** but they didn't force me to go in but I thought "Oh well, I might as well", I gave them a wash afterwards ... my heart was racing, **I was a bit scared but the nurse explained it to me well.** (p. 6)

For Louise, this was the first time she had seen a deceased person, her experience shaped by the nurse she was with. Louise was able to describe her embodied experience in how she felt when she saw her first deceased person. She remembers feeling scared, juxtaposing her feelings of fear is also her pragmatic approach. Although she describes this as a confronting experience, the nurse who showed her after death care was able to support and reassure her, explaining the care to her. Louise was to experience similar feelings and responses during the simulation where she was to witness the moment of death for the first time.

4.6.2 Louise's Simulation Story

4.6.2.1 Thread 5: Managing self amidst an unfamiliar landscape of death and dying

In comparing clinical end of life care with simulation, Louise told me that she found the dying scene (where the patient takes her last breath) to be the most memorable and confronting, primarily because she had not witnessed the moment of death until the simulation:

The **dying phase was very confronting** ... I have seen dead bodies ... after they have died ... but **I have never actually witnessed someone die** (p. 3) ... **it was scary** ... I've experienced the cleaning of the bodies ... but ... not being here. (Dying scene, p. 5)

For Louise, witnessing the patient dying in the dying scene confronted her with an unfamiliar landscape of death and dying. In Louise's storyline, the care of the person after death is objectified and there is almost a sense of detachment of Louise from this process of dying.

4.6.2.2 Thread 4: Managing self amidst negotiating difficult conversations at the end of life

Playing the role of the RN in the nausea and vomiting scene, Louise did not know how to answer the question "Am I dying?":

She was asking if she was going to die ... **I didn't know how to answer** that ... I was a bit taken aback ... bit surprised ... I just went blank ... **no idea what to say.** (pp. 6-7)

Uncertainty surrounding difficult conversations resonates throughout Louise's discourse. Like other participants, Louise also was unsure in how to respond to difficult conversations at the end of life. I catch a glimpse of her feelings, in how she expressed surprise when confronted with difficult questions in simulation. I am left wondering how Louise will manage difficult conversations in the future as an RN, perhaps this simulation will stay with Louise, and remind her that she has managed difficult conversations in the past and can draw on these experiences.

4.6.3 Louise's Intertwining Thread/s

Louise's short story centres around being supported by other nurses in her first clinical end of life care experiences (Thread 1) and being confronted amidst the unfamiliar landscape of death, the physicality of the dying process, and taking the final breath during simulation (Thread 5). Louise found she did not know what to say and struggled with negotiating difficult conversations at the end of life (Thread 4). Thread 1 intertwines with Bree's experiences.

4.7 Getting to Know Bree

Bree, aged 23, was a very confident young woman who participated regularly through open discussion and interaction throughout her undergraduate degree. Like many of the participants, I had also known Bree since the beginning of her nursing degree. Bree was eager to participate in my research and was among several students who had had some life experience prior to undertaking her nursing degree. Bree had also completed a qualification as an EN during her nursing degree and, at the time of the simulation, was working as an EN part-time, which had enabled her to work in a local health service during her studies, gaining some clinical experience along the way.

I met Bree for the interview at a local hotel, seven months after the simulation experience. We found a quiet sunny corner and sat comfortably, on the lounge chairs. This made the interview more casual and comfortable. We both laughed throughout the interview as Bree openly shared her feelings and experiences with the simulation and end of life care.

4.7.1 Bree's Background Story

Bree's background story includes her previous experiences with after death care, as a student nurse on clinical placement seeing a deceased person for the first time. However, Bree had not actually witnessed a patient take their last breath, until the simulation.

4.7.1.1 Thread 1: The role of others in shaping death experiences (humour)

Bree describes one of her first experiences with providing after death care whilst on a second year clinical placement before the simulation experience:

I hadn't seen anyone or been close to seeing anyone [dying] ... I asked if I could help clean down the body ... I helped put him in the body bag ... and then went to the morgue and that was the craziest experience ... [the wardsman] went ahead ... put a mask on and jumped out ... I screamed my head off ... **it was so funny**, it just topped off my first time to the morgue and I'll always remember that ... maybe I was a bit spooked because I had never been there (p. 12) ... I remember his stiffness [the patient] kind of freaked me out (p. 13) ... that [he was cold] was a bit ... weird. (p. 15).

Bree's experience was shaped by others who made this experience fun for her and made light of an intense situation. Bree's language personifies the physical characteristics that embody death causing her tension, further reinforced by the objectification and disembodiment of placing the person in the body bag. A binary of the tension from her first experience with a dead body and what was turned into a fun experience is evident. However, the role of others (the wardsman), in making this a fun experience for her, smooths out this tension for Bree.

4.7.2 Bree's Simulation Story

Bree's simulation story begins with playing the role of the daughter in the dying scene. The most dominant storied fragment for Bree was witnessing dying for the first time in simulation (like Louise and Noah) and the realism of this versus knowing simulation is not real.

4.7.2.1 Thread 7: Real versus unreal landscapes in simulation

Playing the role of a family member during the dying scene, Bree considers the real versus unreal landscapes of simulation:

Having those actors and in Scene 5 (the dying scene) ... with the noises, because I haven't heard those types of noises, the breathing ... I think **the environment is what makes it unrealistic** ... you didn't really know you were in the hospital (p. 10) ... there's other students and lecturers around ... maybe one side could be kept just for simulation ... that might make it feel like "Oh okay, we have to act differently in here ... This is where you come to go to the hospital". (p. 11)

Although Bree feels the simulation was quite realistic, her thoughts bump up against each other when she considers the environment of the simulation laboratory to be unrealistic. Delving deeper into her feelings, Bree explains that the social element adds to the unrealistic nature of the environment with the presence of other students and lecturers. Additionally, the physical environment of the clinical laboratories was a space that Bree was very familiar with throughout her nursing degree. The simulation clinical laboratories caused some tension for her as these spaces had a dual role in her learning, not only as simulation spaces but also as spaces of learning and applying clinical skills.

4.7.2.2 Thread 6: Defining moments in time (looking to the future)

Although Bree has not had any clinical experiences with dying patients following the simulation, Bree talks about how she might feel looking into the future when she does experience her first death in clinical practice:

It will be interesting ... it is going to come and I don't have that experience. **I am out in the real world now and I might be alone.** It might have been better to have experienced ... **it could be scary** (p. 45) ... I will definitely learn from that [simulation]. (p. 47).

Looking ahead and looking inward, Bree searches for how she might feel in the future when she does experience her first death during clinical practice. Caught in the midst of a liminal space, Bree is struggling with the tension of not experiencing death and finding relief that she has not yet experienced this. In contrast, she is concerned about experiencing this for the first time and this will be a defining moment for her. This paradox causes tension and uncertainty. Despite this tension, she does feel some relief knowing that she has had these simulation experiences and has learnt from the simulation and will bring her experiences with her into her clinical practice. Her stories are shaped by past stories and these reshape future stories that leave me wondering what future end of life care experiences are in store for her.

4.7.3 Bree's Intertwining Threads

Bree's first after death experience was shaped by others who made this into a fun experience for her (Thread 1). Despite Bree's thoughts that the simulation was not real (Thread 7), she can see looking ahead that she can take this experience with her into her future clinical practice (Thread 6). Bree does not share any linking threads of experience with Sarah, however, they are interlinked within their simulation experiences, travelling alongside each other amidst the simulation landscapes.

4.8 Meeting Sarah

During the intensive residential school, Sarah, an experienced EN, and two of her closest friends, Hannah and Millie (also experienced ENs), approached me together to volunteer for my research.

Like Renee, I had not met Sarah before and was excited when she approached me stating that this was a topic of interest to her. Sarah, one of the oldest participants, aged 43 years, an EN of nine years at the time of the interview, shared lots of experiences with end of life care. At the time of the simulation, Sarah worked as practice nurse in a GP clinic as an EN, and plans to continue to work there as an RN after completing her degree. Consequently, she had no clinical experiences with end of life care following the simulation experience.

I interviewed Sarah at her home in Newcastle, approximately seven months after the simulation experience. She had invited me to her place to do the interview with her friend (Hannah) who also lived close by. We arranged for Sarah to be interviewed first at her dining room table while Hannah sat outside in the sun listening to some music. Meeting Sarah and her friends during the simulation and interview phase of my research I was struck by how important the social aspects of undertaking the research together were for both Sarah and Hannah.

4.8.1 Sarah's Background Story

4.8.1.1 Thread 5: Managing self amidst an unfamiliar landscape of death and dying

Despite being an EN for several years, Sarah has not been present during the moment of death. However, she vividly remembers seeing her first deceased person whilst attending to post mortem care as a trainee enrolled nurse at a nursing home:

To this day I remember ... someone passed away and they used to take them to this room ... [to] prepare the body, wash it down and gown and wrap ... I was **scared to death** of it, and I didn't know how I would feel because I'd never come in to see a dead body ... I didn't know how I would react ... I just turned off. (p. 7)

Looking back in time, approximately nine years ago, Sarah can vividly remember the unfamiliar landscape of her first after death experience. She clearly recalls the special room for attending to after death care. The structural focus of the clinical environment of the preparation room suggests a disembodiment of this process for Sarah. Disembodiment is

further signified in Sarah's language of how the body was prepared. The objectification of physically washing down the body, gowning and wrapping, although symbolic in nature, gives the sense of a disconnection and detachment. There is also some contradiction where Sarah says she felt scared to death of seeing her first deceased person, opposing the detachment of her other thoughts and causing tension in her discourse. To cope with this uncertainty, she found she 'turned off'.

Sarah further describes this experience, reliving a particularly memorable incident during her first after death care experience, several years ago:

What **confronted me** the most was **wrapping them in the plastic** ... I thought "Oh she can't breathe" ... I was confronted about wrapping her in plastic [laughs] ... I thought "What if she starts breathing again, I've just wrapped her in plastic?" ... and they used to put a single red rose on top of them ... and the rose flew off [laughs] ... I thought "Oh my goodness" ... I was scared [laughing] ... and it was cold, the room was freezing, where they prepared the body was always cold ... it is just cold ... it was just eerie [expression in voice] ... it was always cold ... it just felt really cold ... Spooky ... it had a distinctive smell, too ... like death ... I can't explain it, the coldness and the smell, as soon as you walked in, you knew ... it is weird, really weird ... [laughs] I don't know how to explain that ... **I'll never forget it.** (pp. 13–15)

In this first unfamiliar landscape of death and dying, Sarah's awareness that the patient could not breathe adds to her own inner embodied feelings of not coming to terms with death, and the quip 'scared to death of it' shows she was confronted by wrapping the person, post mortem. There is tension in what Sarah is feeling, on one hand, there is objectification of the body and disembodied ritualised processes of wrapping that depersonalises the patient. While on the other, the ritual of placing a single red rose, symbolising humanised care. Although this storied fragment initially bumps up against itself and suggests a binary of dehumanisation versus humanisation, these conflicting notions are resolved through the humanised placement of the red rose.

Through the telling of her vivid story and drawing on my own death experiences, I can feel the coldness and sense what this distinctive smell was like. Despite the passage of several years across the time continuum, Sarah still clearly recalls this experience, which has become a powerful story of an unfamiliar landscape of death for her. As she moves backward in time, this memory still evokes strong feelings and causes her to laugh out loud whilst reliving this experience. To me, Sarah's laugh, one almost of incredulity, relieves tension for her. I can see the shock displayed on her face as she laughs and recalls this experience, an experience that has travelled with her through time and across landscapes, and I wonder whether this experience will continue to travel with her through time and across landscapes.

4.8.2 Sarah's Simulation Story

Sarah's simulation story begins with the final scene in the simulation, the dying scene. Sarah starts reliving her simulation experience with the nausea and vomiting scenario, the scene that has the most impact for her.

4.8.2.1 Thread 4: Managing self amidst negotiating difficult conversations at the end of life

Sarah did not find the simulation confronting; however, she was worried about telling family the wrong thing amidst negotiating difficult conversations at the end of life, and was worried about their feelings:

I didn't find it confronting ... you worry ... that you tell the family the wrong thing ... and what you are saying to them, that makes them feel better ... I am not worried about how I feel, I am worried about how they are feeling ... **You want to say the right things** to them and you want to do the right things with them because it is a hard time for them. (p. 3)

There are some contradictions and repetition in Sarah's discourse. She does not find the simulation confronting, however, she is concerned about how she will manage the difficult conversations with family without saying the wrong thing. In managing herself amidst difficult conversations, a paradox reveals itself. Sarah's main concern is not about her own feelings but instead she is concerned about the patient's and family's feelings.

4.8.3 Sarah's Intertwining Threads

The dominant storyline for Sarah was not knowing what to say when confronted by difficult conversations (Thread 4) during the simulation. The ritual wrapping of the person post mortem was an unfamiliar landscape for her (Thread 5). Although these are common threads that link Sarah to other participants, there are no linking threads of experience to the next participant, Hannah. Instead, Sarah and Hannah share similar experiences in their professional landscapes as experienced ENs as well as in personal landscapes as close friends undertaking university studies together.

4.9 Getting to Know Hannah

Two days before the simulation session, Hannah and her two friends (Sarah and Millie) approached me together. I was delighted that Hannah and two of her friends had volunteered to participate in my research when none of them had met me prior to this. On first meeting Hannah, I found her to be very quiet and softly spoken. An older student, aged 43, Hannah, like her friends, had been an EN for several years before undertaking her nursing degree to transition to become an RN.

I interviewed Hannah at her friend Sarah's house, approximately seven months after the simulation experience. After interviewing Sarah, Hannah and I moved to the living room with a cup of tea to start our interview.

4.9.1 Hannah's Background Story

At the time of our interview, Hannah had been an EN for approximately nine years and has gained many experiences with end of life care, both in a hospital and nursing home setting. Like the other students undertaking my research, at times Hannah's stories of end of life care intertwine across her nursing experience as an EN and as a student RN.

4.9.1.1 Thread 2: Attending to family at the end of life

In this thread, Hannah reveals how important families are at the end of life:

I put a lot of care into palliative patients and **family** and some nurses ... say "There's too many people in there ..." and I say "If that was my mum or dad there would be a lot of people [there] (p. 21), they all need to be there" ... "They all need to be there". (p. 22)

Hannah shows a lot of compassion and care for her patients and their families at the end of life. Her vast experience with palliative care gives her the confidence to care for palliative patients well. Her feelings about the importance of family are all the more poignant as she relates back to her own family. The use of such repetition also shows how important it is to her that family are able to be present during this time. There is tension for Hannah with some nurses' attitudes towards family by the bedside causing her feelings of frustration. Expressing her feelings of frustration with other nurses affirms her passion for caring for the person and families at the end of life. I wonder and hope that Hannah's passion for end of life care continues throughout her nursing career.

4.9.2 Hannah's Simulation Story

4.9.2.1 Thread 7: Real versus unreal landscapes in simulation

Looking back to the simulation experience during her participant interview, Hannah felt that simulation does not feel real. Hannah's simulation story begins with the nausea and vomiting scene.

With simulation I feel uncomfortable ... it seems so staged and **not real** ... and you are thinking what you have to do ... I just feel uncomfortable ... Because it is not natural to me, where in the real world ... to me it just comes naturally (p. 2) ... because it wasn't real, because it wasn't real and **you had to act in a way** (p. 3) ... it just doesn't come natural (p. 5), like when I am working I just do stuff and I just know what to ask but when I am put in a situation like that where I have got to think it, break it down, I struggle a bit. (p. 6)

The binary of real versus unreal underpins Hannah's discourse. The use of repetition and negative descriptors highlights her feelings of insecurity and uncertainty. Her feelings of being an actor in a play are interesting. For some students, such as Hannah, this play acting is seen more as live theatre and acting out roles rather than viewing simulation as a chance to practise being a real RN practising skills and communication.

Although in the previous comment, Hannah talks of the simulation as not being realistic, this is contradicted later in the interview where Hannah's storyline bumps up against an opposite point of view, causing tension, where she feels that one particular scene (the unconscious scene) was realistic, as seen in the following storied fragment:

He was a really good actor so I actually felt quite comfortable like **as if that was real**. He [Doris's son] was really good ... so I actually did feel quite comfortable with that because I think he was so good. (p. 12)

The reality of the simulation in this instance is reinforced by the actor playing the role of the son realistically, and repetition of this reinforces the realism of simulation being dependent on the actor's ability to come across as authentic in their portrayal. To Hannah, this scene felt more real in comparison to the end of life scene where the patient was a manikin. However, there is tension as this storied fragment bumps up against her previous comments that the simulation felt unrealistic.

4.9.3 Hannah's Intertwining Threads

Hannah's stories reverberate with tensions between unreality versus reality in simulation (Thread 7). The importance of family and providing family centred care (Thread 2) is also

significant for Hannah. Similar to Sarah, Hannah does not share any linking threads of experience with the next participant, Lauren. However, as research participants, their simulation experiences are interconnected and interwoven.

4.10 Introducing Lauren

Lauren, a bright and bubbly young woman, aged 23, like others (Bree and Holly), came into her nursing degree from high school. While undertaking her undergraduate nursing degree, Lauren worked as an AIN in a local nursing home for two years. As Lauren's stories unfold, her clinical experiences as an AIN and a student RN intertwine.

Lauren, like other students (such as Holly, Bree and Luke), I knew from the beginning of her nursing degree, about two years prior to the simulation. Lauren was one of several students who were good friends (Luke, Simon, Claire and Bree) who volunteered to participate together so they could share these experiences.

Lauren was living on the coast when we met at her parent's unit to undertake the interview, seven and a half months after the simulation experience. I remember the day we met was a beautiful sunny day. It was the summer holidays, one week before Christmas and I had driven down the mountain to the coast the day before with my daughter, who was on school holidays. We had arranged to meet at her parent's place where she was living until she would move to Sydney to take up a post graduate position at a children's hospital there, half way through the following year.

4.10.1 Lauren's Background Story

4.10.1.1 Thread 1: The role of others in shaping death experiences

Lauren's central storyline is about her first death experience at a local hospital whilst on her second clinical placement during the first year of her degree, and how the nurse facilitator looked after her, walking her through this experience:

I was with a fantastic nurse (p. 19) ... I knew she [the patient] had passed away ... and I was quite freaked out, but the nurse was so good ... and she's like "Have you ever done the after [death] care?" and I was like "No" ... she was like ... "I will tell you about my first experience" and all the other nurses, they were "This happens all the time". It was the best place for it to happen because it did frighten me but the nursing staff were amazing ... And I remember that because we went through the whole thing, we put the tags on ... and they were like "No, come on, you are doing the whole thing

because **you won't forget this now**, it is something that you will remember and hopefully learn from it and you know what other students are like if they haven't dealt with a (p. 20) dead body before ... it happens to everyone, it is a normal reaction for you to freak out" ... she was the best nurse ever ... I did have a tear ... but that is normal ... I will never forget that ... I wouldn't have known what to do if I was by myself (p. 21) ... just that little bit of help can change that first experience that **you will never forget**, to a good or a bad one. (p. 22)

The social aspects of care and support at the end of life reverberate across Lauren's stories of her first experience with after death care. The nurse took the time to walk her through the steps of after death care and helped shape this into a good experience for Lauren. Throughout this experience Lauren moves through a range of feelings, from fear to finally feeling supported and reassured, so much so that she did not feel alone on this journey and was reassured that her feelings were normal. Time is also relevant, this was the first time Lauren had experienced death in clinical practice, and feels that this is something that she will never forget. As Lauren travels back in time to relive this experience, I see an embodied response of a tear in her eye, just like she had during her first death experience, these small tears bridging her experiences across borderlands and crossing these borders across time.

Going into her second after death experience, Lauren felt confident because she had a good experience previously:

I was happy to deal with the dying resident ... I felt comfortable (p. 25) ... **I felt like I could do it** ... I know what I am doing, I am leading this ... it was good because after having such a good experience beforehand ... **I felt confident** that I could do it and I could talk to the family (p. 26) ... I thought it was good from not having any idea what to do on my first one, to then being able to confidently do the second one ... I would much prefer to see everything while I was a student than having to face it for the first time as an RN ... I knew I would always have someone to help me. (p. 27)

The impact of the care taken by other nurses to support Lauren travels with her and has shaped her experiences, giving her the confidence and the ability to shape other nurses encountering their first death experiences. Her experience has also given her the confidence to talk to the family at the end of life. Her use of repetition reinforces her confidence. Travelling through time and across liminal spaces, it is evident how Lauren has been professionally shaped by the nurses during this first experience. She moves from firstly being uncertain of what to do during the first experience to then moving ahead to her second experience, where she has the confidence to take the lead, showing how much she has learnt from the nurses who have shaped her experiences. I wonder how these experiences will continue to shape her as she becomes a new RN in the near future.

4.10.2 Lauren's Simulation Story

4.10.2.1 Thread 3: Theory, practice and experience become synergised

Lauren's simulation experience begins with the pain scenario. Moving ahead through the scenarios, Lauren clearly remembers the unconscious patient scene as the most memorable and the most challenging. During her participant interview, she recalls her feelings when dealing with Doris's son and how she learnt to manage the situation by the end of the scene, merging theory, practice and experience:

I remember ... how nerve racking it was at the start, talking to him [the family member] and then by the end of it ... you knew what to say even in that short five minutes ... I remember distinctly number four [unconscious scene] because it was so beneficial ... it was really easy by the end of it to talk to and say some bad news to the family members [Doris's son] (p. 1) ... it was really good to do it because you learnt, you were put in the situation so **you had to know what to say** ... you had to like sympathise and empathise with him because he played the person so well and you were just like "Oh my, it is her son!" ... and you are put in the situation and you have to deal with it ... you have to be able to talk to them and have to **put yourself in their situation**. (p. 2)

Lauren's comments depict the impact that end of life care simulation has had for her. Although Lauren felt that this scene was the most challenging, she found that by the end of the scene she knew what to say. Despite being put on the spot in the simulation, Lauren was able to draw on her previous experiences with exceptional nurses who have travelled with her, and apply what she has learned into the simulation scenario.

4.10.2.2 Thread 8: Finding comfort amidst learning and working together

Lauren found comfort in working with peers, the impact of end of life care simulation evident in her comments.

the comfort of being with friends ... you can trust them and ... you will always have someone to back you up ... I find I work well in the simulation and the practical side of that ... and I feel at the end of it that I have learnt a lot more. (p. 1)

The sociality of simulation and interaction with her peers is important to Lauren in the learning process. Lauren also felt that the practicalities of the simulation promoted learning.

Further on in the interview, Lauren talks of the importance of sociality of simulation:

The simulation was good because you got to **bounce ideas off all of the groups** ... The debrief was good because you got to go “I did it this way and I found that really worked” ... you can see how other people do it and see what works best so that you can incorporate it into what you have got to do when we are all registered. (p. 17)

Lauren’s comment reinforces the social nature of the simulation and the social nature of learning and working with peers. For Lauren, the simulation debrief was particularly good because she could learn from other groups’ experiences. Learning and working together with her peers gives her the confidence that she can incorporate her learning into her future clinical practice as an RN.

4.10.2.3 Thread 6: Defining moments in time: Looking to the future

Lauren did not have any end of life experiences after the simulation to share, however, she felt she could relate her simulation experience to communication she has had in clinical practice since the simulation:

[communication skills] definitely increased, **I feel like I would be able to ... in a tough situation where you are trying to deal with family members**, I definitely think I would be able to say the hard things and talk about it with them, because ... we had such a good simulation, I feel like it was so beneficial because ... you had to be put in that situation and you knew that it was a simulation, ... but because it was so well done ... you felt like you were actually in the situation ... everyone took it so seriously that it felt so real ... I feel like it was the perfect way to do it because ... **if I was in that situation I would definitely know how I would be able to deal with it now.** (p. 20)

In the above storied fragment, Lauren feels the simulation increased her confidence with communication at the end of life. Reiterating some of her thoughts from earlier in the interview, space and interaction intertwine giving her a sense that she was actually in the situation. Looking ahead and border crossing across liminal spaces in time, she feels that if she is faced with a similar situation in the future she has the confidence to deal with it.

4.10.3 Lauren’s Intertwining Threads

Lauren’s key threads involved the role of others in making death experiences positive (Thread 1), the sociality and comfort of peer learning (Thread 8), and simulation integrating theory, experience and practice (Thread 3). Looking ahead, Lauren now has the confidence

that she can manage end of life care in the future as an RN (Thread 6). Lauren and Millie are interlinked together by two threads of experience (Threads 1 and 3).

4.11 Meeting Millie

I first met Millie when she approached me with her two friends (Sarah and Hannah) during the intensive residential school. Millie, aged in her early 50s, was the oldest of the research participants. My first impressions of Millie were that she was a very professional, competent nurse and an outgoing and generous person. Millie spoke confidently and introduced herself and her colleagues, telling me of her passion for palliative care and about her many years of experience as an EN. I found out very quickly during the simulation and debriefing that Millie was a very experienced EN with 27 years of experience.

Meeting up with Mille for our interview, a little over eight months after the simulation, I was feeling a little hesitant about our meeting. I had only met Millie on two other occasions, the first, when she approached me to volunteer for my research and the next, when we undertook the simulation and the first phase of my study. We decided to meet at a place convenient for her since I had already driven down to the coast the day before the interview. Millie was working that day so we agreed to meet after her shift finished at the local hospital. When we arrived at the meeting room, I realised that I had been there previously, in what felt like another life time, in my role as a Palliative Care Clinical Nurse Consultant (CNC). Revisiting this room gave me a sense of *déjà vu*, reminding me of my previous role. During the interview we chatted like old friends catching up after a long absence. I soon discovered that my anxieties and hesitancy about meeting up with Millie were unfounded. Looking back, I remember feeling anxious because I did not know Millie very well. However, her warm and welcoming nature quickly put me at ease. As our interview unfolded, it was clear that Millie had a lot of experiences with end of life care to share. I was left with a feeling that we could have talked for hours about her experiences.

4.11.1 Millie's Background Story

4.11.1.1 Thread 1: The role of others in shaping death experiences (will never forget)

Millie's story begins with her first experience with death and dying as a young trainee enrolled nurse at a local nursing home at the age of 18 years. Millie (like Sarah) remembers clearly her first experience and how this was shaped by the nurse she was with. This experience reverberates throughout her many other experiences in between as she says:

I remember it like it was yesterday ... and **I have never forgotten the first time** ... and ... I remember her name [the resident]... and she had a funny personality and she just somehow shone through, and she died, and I remember having to gain the confidence to walk over and touch her. I was as nervous as anything ... I didn't see her pass away but I was there probably within twenty minutes of her dying ... I didn't lay her out ... but I did go and touch her and sit with her for a while and **I will never forget it, never forget it** ... It was me that wanted to do it (p. 29) ... And I have never forgotten that and as a consequence I am always fairly careful [now] about young ones that have not been nursing for very long and if that's their first experience. I try to allow them to have the same experience I had because that's really important ... so many other people in between you might forget but **you never forget the first one** ... (p. 30) you need to really go gently, gently. I remember being allowed to go there in my own time and ... and **it was a nice experience** ... They [the nurses] told me that she had died and how did I feel ... so there was that bit of prep [preparation] ... it was a good experience. (p. 31)

While Millie is reliving her story of this first experience, as a young 18-year-old, I have a real sense of how significant this experience was for her and how much of an impact this has had on her clinical practice over 30 years later. Millie's first experience with end of life care was such a good experience for her because of the nurses she was working with who allowed her to go in her own time, did not pressure her nor rush her through this experience. This positive experience has impacted on how she now works 'gently' with other students. This was such a poignant experience for her, she felt that she would never forget it.

Temporality intertwines across sociality, reflected in how easily Millie can recall her first end of life experience, even remembering the resident's name and her personality. Millie feels that the first experience is always going to stay with you.

Millie's own story resonates with my own first end of life experience and I find myself wondering the reasons for this: is it because the experiences, either good or bad, travel with us and form part of who we are and who we are becoming in our nursing practice? Is it because this is a new experience about death and the unknown, that it stays with us? For me, this triggers more questions than answers. For this reason, her comments resonate with me as I am swept back in time myself to my own very first end of life experience as a new student nurse. Like Millie, I too, was only 18, and I too, still remember this experience as if it was yesterday. But, unlike Millie, my own first experience, contrasting starkly with her experience, was shrouded in fear and overwhelming feelings of distress. I remember how I was plummeted into this experience with no preparation and no clear understanding of what I was about to experience and how I later cried in an attempt to deal with my confusion and emotions. Millie's first experience of death had a huge impact on her. Like Millie, my

experience has impacted on me personally and professionally and has resulted in my passion and dedication with providing positive end of life care experiences for other nursing students experiencing end of life care for the first time.

4.11.2 Millie's Simulation Story

4.11.2.1 Thread 4: Managing self amidst negotiating difficult conversations at the end of life (humour)

Millie's simulation story begins with the unconscious patient. Moving through the scenarios, the final scene for her (the nausea and vomiting scene), playing the role of the RN, brings forward a degree of tension as Millie attempts to negotiate difficult conversations and deal with the question "Am I dying?". In the simulation debriefing Millie says:

"Not on my shift!" (p. 17)

Millie's initial response to managing herself amidst difficult conversations was to revert to the use of humour. However, there is a sense of tension in her comment, Millie knows that she would not say this in clinical practice but made this comment in the simulation debriefing surrounded by her peers. I am left wondering why Millie would make such a remark: was she embarrassed in the simulation? Perhaps she said this to diffuse the tension and stress in the scenario through the use of humour. Or perhaps this is because of her confidence in her own abilities gained through many years of nursing experience. Millie's reaction here conflicts with what she has previously shown during her discourse and further bumps up against what she says in the future, during her participant interview.

During her interview, playing the role of the RN in the nausea and vomiting scene, Millie said that she did not have a problem with the question "Am I dying?", despite her previous comment "Not on my shift!".

I have dealt with that lots and lots and lots of times ... I remember saying "Yes, you know you are, do you want to talk about it, how do you feel?" (p. 11) ... everyone is tip-toeing around them or their family. No one wants to say it and you might be the first person they actually say "So I am dying, am I?" to... allow them to discuss it and listen. (p. 12)

Millie's reactions and responses to difficult conversations here bump up against how she initially reacted during the simulation debriefing, when she made the remark "Not on my shift". In her discourse here, she seems to have recovered herself and was then able to respond in a caring and compassionate manner. However, as shown in her comment, nursing clinical practice is often filled with tension that is often dissipated through the use of humour.

4.11.2.2 Thread 3: Theory, practice and experience become synergised

In this storied fragment, Millie shows how theory, practice and experience became synergised for her and how this has impacted on her clinical practice. Giving an example, Millie discusses the nausea and vomiting scene and how her medication knowledge has improved:

That experience with the bowel obstruction and the Maxalon versus Ondansetron also sticks in my mind ... Since then, I have [had that experience] and I made the choice ... in fact, I have challenged a doctor [laughs] (p. 37) ... “Would Ondansetron be more effective?” I have done that and **I will do that all the time** [laughs]. (p. 38)

Millie felt empowered by the knowledge that she has learnt in the simulation and felt able to apply this new knowledge to her clinical practice. Looking ahead, Millie feels that she will continue to do this in the future. Looking to the future, I think to myself, and wonder, whether Millie will continue to feel empowered by the knowledge she has gained throughout her nursing degree and during the simulation experience.

4.11.3 Millie’s Intertwining Threads

Time and sociality intertwine throughout as Millie negotiates difficult conversations at the end of life (Thread 4) and how theory, practice and experience become synergised (Thread 3) and carry forward through time to intersect with future experiences. The role of others in shaping positive death experiences (Thread 1) is the interweaving thread that links Millie to the next participant, Claire.

4.12 Introducing Claire

Claire, a quiet and respectful young woman, aged 20, was one of the students I first met during the first year of her nursing degree and like other students (Holly, Louise, and Poppy), she had come straight into her nursing degree from high school. Also like other students, Claire was working her way through university as firstly, an AIN for one year and then as an EN for the past six months at a local nursing home.

For our interview, I had arranged to meet Claire at a local café, just over eight months after the simulation experience. I clearly remember this day, it was a hot summer morning and we had arranged to meet for coffee. I chose this particular café because it was quiet, open and bright and because we were both familiar with it. Although all my previous experiences at this

café led me to believe this was a good choice for our meeting, I was soon to discover that this was perhaps not the quietest place to sit and chat. Shortly after we began, the noise of the coffee grinder commenced and continued for most of the interview; not only this but the cafe worker then dragged out the vacuum cleaner and commenced vacuuming around us, completely oblivious to our interview. I had to laugh to myself thinking that life just continues on around you, no matter what is happening.

4.12.1 Claire's Background Story

4.12.1.1 Thread 1: The role of others in shaping death experiences (feeling protected)

Reliving her first death during clinical placement as a student nurse, Claire talks about the support provided by the RN who shaped her experience. As her story unfolds, the RN is trying to shield her from her first after death experience:

The nurse ... **was trying to protect me** so she'd be like "Oh, you can wait outside" and I'm like "No, I'll come in and help" ... I'd turned 18 (p. 25) it was our first time ... and we just sat back and took it all in (p. 26) ... and asked me if I wanted to talk about anything ... and because she [the nurse] was so young as well, we could relate to each other (p. 27) ... the nurse was explaining what was going to happen ... and I was just standing there taking it all in. (p. 34)

Sociality, spatiality and temporality are intertwined in Claire's story. In this storied fragment, sociality is central for Claire as she recalls the support she received shaped this into a positive experience for her. For Claire, there was an overarching feeling of protection from the nurse. This was also a good experience for her because she felt connected to the nurse who was of a similar age to her, and she felt she could relate to her easily throughout this experience. Experience and learning from others are central to Claire's story. As Claire's transitions from an EN to an RN in her near future, I am left wondering of the impact of this protection by her RN and how this will in turn affect how she will support other student nurses experiencing death for the first time in clinical practice.

4.12.2 Claire's Simulation Story

4.12.2.1 Thread 8: Finding comfort amidst working and learning together

Claire's comfort of working through the simulation with her friend and peer is highlighted as she talks of the simulation experience:

I felt really comfortable ... because Lauren and I got on really well ... we kind of just talked to each other through it ... if I was with two other people I didn't know I would have felt more uncomfortable. (p. 38)

The sociality of the simulations is important for Claire. Being with her friend, Lauren, someone who she had a connection with, made this a more comfortable experience for her and enabled them both to talk through and work through the simulation together, sharing this experience together.

4.12.3 Claire's Intertwining Threads

The sociality of learning together (Thread 8) during Claire's simulation experiences reverberates throughout her stories of simulation. Central to this is also the overarching thread of the role of others in shaping end of life experiences (Thread 1). It is both these social threads (Threads 1 and 8) that link Claire to Grace.

4.13 Getting to Know Grace

Grace was one of the older students, aged 41, who undertook her RN degree later in life. Working as an AIN in a rural town for two years at the time of the simulation, Grace was able to share many of her experiences with end of life care, which were both deeply personal and clinical. Like other participants, I had come to know Grace from the first year of her degree. Although Grace was a mature aged student, she did not possess as much confidence as many of the other students in the study, around her age. I have always found Grace to be softly spoken and respectful.

We met up for her interview at her local town; I had driven there that morning with a friend of mine who went shopping while I interviewed Grace at the local TAFE. Grace's interview was in mid-January, approximately eight and a half months after the simulation experience. I clearly remember meeting Grace that day, it was very hot and we had already driven an hour and a half in the heat. I remember walking a couple of blocks toward the campus and was struck by how dry the campus looked. We had planned to meet in the library, anticipating the heat of the day, but when we arrived, the campus library was closed for the school holiday

period. There was little shade and lots of mosquitoes, so we decided to take advantage of undercover seating outside one of the demountable blocks. Grace apologised for the environment and showed her uncertainty at what the interview might entail. I quickly reassured her that the interview was only for my doctoral research and that no one besides myself and my supervisors would have access to the information she provided during our meeting. Grace visibly relaxed after my reassurance.

4.13.1 Grace's Background Story

4.13.1.1 Thread 5: Managing self amidst an unfamiliar landscape of death and dying (a dehumanising clinical landscape)

Grace talks of her first after death care, an unfamiliar landscape for her, whilst on her first clinical placement at the nursing home where she now works:

One of the nurses ... said "This patient died about an hour ago, we need to bag him" ... **I had never seen anyone get bagged before** ... I didn't see him die but I had seen him a couple of hours beforehand and he was doing the whole breathing thing ... I had a bit of a moment (p. 22) ... it was just moving the whole bag ... and you are seeing him zipped in the bag, it was like "Oh!" (p. 23) ... it was a shock, it was like "What's going on here?" ... it didn't [seem real] they just had him in a blue bag. (p. 23).

Grace's use of language "bag him" suggests a sense of disembodiment and a distancing ontologically from this experience. There is tension in what she says, she had seen him breathing not long before and then moving forward in time, she is confronted by witnessing him being placed in a blue bag. End of life in this instance signifying a binary of humanisation and dehumanisation, Grace's story here runs alongside Sarah's story of seeing the deceased "wrapped in plastic". To her, this didn't seem real, the ritualistic placing of the deceased in a "blue bag" enhancing this disembodiment at the time of death, similar to feelings shared by Sarah in her storyline.

4.13.1.2 Thread 2: Attending to family at the end of life

In comparing personal experiences with clinical experiences, Grace views care along the lines of what she would want for her own family:

My view is if that was my grandfather or grandmother, how would I want them to be treated, I mean they are **people's family** (p. 23) ... especially when they are dead.

It is an **honour** to be doing that thing for them, it is personal, and the fact that you are helping that person and ... helping the family. (p. 24)

Care of the family at the end of life resonates throughout Grace's discourse here. Temporality, sociality and space are simultaneously embedded throughout. The moments in time of significance are those precious hours prior to death, for attending to the patient as well as the family, and after death, is an honour to provide after death care. For Grace, this time is also very personal, relating this back to how she would like her grandparents to be treated.

4.13.1.3 Thread 1: The role of others in shaping death experiences

Grace's first end of life and post death care experiences have travelled with her across time, in this instance she talks of how nurses shape these first experiences:

We [myself and the other nurse] did the whole ... cleaning up ... and we ended up sitting down and having dinner and **just talking** over dinner (p. 25) ... and the nurses that I had with me, because I could have had one that was insensitive ... but I was lucky in that sense to have who I had with me. (p. 26)

Grace recalls the support given to her by the nurses who helped her undertake the ritualistic post death care and talked to her about the experience. Grace's story highlights how other nurses shape experiences of death and dying for those nurses who have not had these experiences before.

4.13.2 Grace's Simulation Story

4.13.2.1 Thread 2: Attending to family at the end of life

During Grace's interview, she recalls the dying scene in the simulation which was the most memorable for her, because of previous personal experiences with dying family members. During this scene, Grace, playing the role of the family, found this experience enabled her to express her feelings remembered from her grandfather's death:

It was intense ... going through the emotional stuff and going back to my own grandfather (p. 2) ... the whole family ... gathered around the bed (p. 3)... it helped by going through it, you see how important actually expressing your feelings and going through the steps was **and just being one of the family members** ... it was (the scene that had) the most impact one (sic). (p. 4)

Finding this scene intense and emotional caused Grace to reflect back to her grandfather's death several years previously, further highlighting the importance of care of the family at the end of life. Situationally, playing the role of a family member, she could see the relation of this simulation experience with her own personal experience of all the family gathered around the bed, the simulation bridging across time and place.

4.13.2.2 Thread 8: Finding comfort amidst working and learning together (it wasn't just you)

Grace found simulation debriefing to be helpful in the learning process:

It did help, **the fact that we could sit and talk, the group talk** (p. 12) ... and realise that **it wasn't just you**, that's one thing we need to remember, that we aren't alone in that, we can call on others. (p. 13)

The social aspects of simulation and the debriefing are dominant in Grace's discourse here. The act of sitting and talking was crucial in providing the space to come together to share their experiences and hear what others had experienced. It was important for her to know that she was not alone in these experiences.

4.13.3 Grace's Intertwining Threads

The primary threads that resonate throughout Grace's stories are about the role of others in shaping death experiences (Thread 1) as well as attending to family at the end of life (Thread 2). In the midst of unfamiliar landscapes of death and dying (Thread 5), Grace was confronted by the ritualistic 'bagging' of the patient. Finally, Grace found comfort in learning amidst others in simulation (Thread 8). Similar to Lauren and Hannah, Grace and Simon do not share any threads of experience. However, they, too, are intertwined amidst their simulation experiences.

4.14 Introducing Simon

From the very first day I met Simon, aged 25, he stood out in a crowd. Always laughing and jovial and very popular among his nursing student colleagues. Simon volunteered to be a participant in my research because he said he wanted to help out where he could.

Simon enrolled in his nursing degree as a mature aged student and had worked in hospitality and travelled, prior to his nursing degree. Simon's first nursing job will soon be as a newly graduated RN after he completes his nursing degree, taking up his new position in the

following month. This lack of nursing experience for Simon has impacted on his experiences, and his feelings of undertaking end of life care unfolded during his interview. Simon's interview took place eight and a half months after the simulation experience, at a local hotel where he has worked throughout his undergraduate degree. We sat in a sunny corner upstairs on comfy lounge chairs, while Simon relived his experiences with end of life care and the simulation.

4.14.1 Simon's Background Story

4.14.1.1 Thread 6: Defining moments in time – looking to the future

Simon was one of the students who had not yet experienced watching a patient die and had rarely looked after palliative patients. Looking to the future, Simon contemplates his first death experience as a defining moment of time in his future nursing career:

I have done heaps of prac [clinical placement] now and I still haven't had a dying patient ... I have never had them die (p. 4) ... **I am going out on my own and I am going to be the responsible one** ... I don't know how to deal with something like that. Imagine if I don't deal with it right in front of the family (p. 5) ... that is my fear ... how to deal with [it]. (p. 7)

I have never seen a dead body ... I don't know how I am going to react ... if I am going to feel woozy or faint ... when it comes to a dead body ... if somebody said to me "Oh, can you go and do after death care" **I wouldn't know what to do.** (p. 24)

Throughout his undergraduate nursing degree, Simon has never experienced the death of a patient and has not witnessed someone taking their last breath. Looking toward the future Simon does not yet know how he will react when he sees a deceased person the first time. Similar to Bree's experience of looking to the future, across the liminal space of time there is an embodied discomfort in his wonderings about his first death experience. Simon's comments reflect his looking inward and the uncertainty, tension and concern he has for looking ahead. In attending to this liminal space of his future nursing practice, he is acutely aware that he will soon be out on his own as an RN, and that he may have to be the one required to undertake this care. Travelling forward in time, Simon is border crossing to another place considering the possibilities of what might be in the future for him as a newly graduated RN. I too am left considering and wondering what future end of life care experiences will be like for him. For Simon, the tension this border crossing creates is as yet unresolved during his interview.

4.14.2 Simon's Simulation Story

4.14.2.1 Thread 4: Managing self amidst difficult conversations at the end of life (saying the right words)

Looking backwards in time, Simon, playing the role of an RN alongside Luke, found the most memorable scene was the unconscious patient, and in this setting, Simon manages himself in responding to difficult conversations:

What sticks in my head ... the unconscious stage where ... [the] anxious son ... as students it was very hard (p. 2) ... I honestly got stuck like **"What do I say"** like, when they are like "Is she going to die?" ... how the scenario was going to go "Well yes" but **it is hard to say, work out the right wording** ... it was very confronting ... I suppose the more experienced, you would be able to deal with those situations but that was the first time ever for me ... it was just like 'Boom!' (p. 3)

For Simon the challenge of managing difficult conversations at the end of life resonates throughout his discourse. Travelling backwards in time during the interview to the simulation, Simon is reminded of the most dominant scene for him, the unconscious patient scenario. Despite the passage of time, he finds that this one particular scenario has struck him and challenges him the most. Using this colloquialism, "what sticks in my head", highlights how this is embedded within his memory and also suggests a point of crisis for him. Playing the RN with Luke, Simon, too, was stuck with what to say. His lack of experience with end of life care resonates throughout this scene. The use of the onomatopoeia "Boom!" in his discourse highlights how much of an impact this has had on him.

4.14.2.2 Thread 3: Theory, practice and experience become synergised (hands on learning)

Overall, Simon thought the simulation was a good experience that enabled him to link theory to practice:

I am a visual learner ... I really like that **hands on** (p. 19) ... **Physically doing things** ... That was my only death experience is that sim [simulation], so I think it needs to be done. (p. 20)

For Simon, this was an important experience because his only death experience was in the simulation laboratory where hands on learning allowed linking of theory to practice. His comment also reflects that end of life simulation is especially needed, particularly for students who have not previously had this experience.

For Simon, the simulation also provided the opportunity to practise communication at the end of life:

It triggered you to think on the spot and to be able to communicate ... it did help with **communication skills** ... because I'd never done ... those scenarios ... it has definitely prepped [prepared] me a little bit (p. 32) ... if I am dealing with death, that's what I will remember ... Is the sim [simulation], and you **learn off previous experiences**, probably the next time I am dealing with that I will remember the first time I dealt with that [in simulation]. (p. 33)

Simon feels that he will be able to think back to the learning in simulation and link theory, practice and experience to help him know what to do in clinical practice. However, uncertainty still surrounds Simon in relation to experiencing death for the first time in clinical practice. Although the tension is so far unresolved, Simon does feel that the simulation has had some impact on his ability to manage this type of experience and he will be able to reflect back across time to the simulation experience and he will remember how the simulation unfolded. Central to this is learning from previous experiences. Simon, like Lauren, feels that the simulation has helped with communication skills at the end of life. However, for Simon, the simulation experience has also given him some insight into what to expect at the end of life, thus easing some of his tension.

4.14.3 Simon's Intertwining Threads

Simon's simulation stories are about his lack of clinical experience with death and dying and managing himself amidst negotiating difficult conversations at the end of life (Thread 4). Linking theory, practice and experience (Thread 3), Simon feels the simulation has helped his communication skills and he feels he will carry these experiences with him into his future nursing practice (Thread 6). Although Simon and the next participant, Poppy, do not share threads of experience, they are interconnected closely within the simulation landscapes, travelling alongside each other amidst the simulation experience.

4.15 Meeting Poppy

When I first met Poppy, aged 20, she struck me as a shy and unassuming young woman who had quiet confidence in her ability as a nurse and nursing student. Like many of the students, I had known Poppy since the beginning of her undergraduate degree. I remember tutorial classes with Poppy (together with Louise) and how she interacted respectfully with her nursing colleagues and with her lecturers.

Catching up with her just under 10 months after the simulation experience, Poppy was then one month through her postgraduate year of nursing, working at the Children's Hospital in Sydney as a newly registered nurse. For the interview, Poppy invited me into her home, a high-rise apartment in the centre of Sydney, overlooking the city skyline.

4.15.1 Poppy's Background Story

4.15.1.1 Thread 5: Managing self amidst an unfamiliar landscape of death and dying (gaining confidence)

Poppy remembers her first death experience and the first time she had seen a deceased person as a first year student nurse on her second clinical placement in a rural nursing home. As an unfamiliar landscape for her, Poppy did not attend to after death care because of a lack of confidence. It was not until she saw her second deceased person that she was comfortable and had confidence to undertake this care:

That was **the first time** I had seen someone that has passed away ... I did care for him at the end ... but he died before my shift started (p. 18) ... I didn't know that he was gone ... it was kind of creepy (p. 19) ... I thought "Wow, I think he's gone" ... I don't think I touched him, I didn't think that I wanted to ... I was scared he was going to be really cold (p. 20) ... I didn't really want to feel that ... a bit shocked (p. 21) ... I had never seen one before. (p. 22)

Revisiting her first unfamiliar experience with seeing a deceased person for the first time has travelled with Poppy across time. As she described this experience, I got a sense of how significant this was for her. Her discourse here resonates with uncertainty surrounding touching the deceased person and not wanting to feel the embodied coldness. Looking inward, she felt scared and shocked because this was an unfamiliar experience for her. Following Poppy's first death experience I am left wondering what other end of life care experiences she will have, and whether these might be within the unfamiliar landscape of care of the dying child in her role as new graduate RN at the Children's Hospital.

4.15.2 Poppy's Simulation Story

4.15.2.1 Thread 5: Managing self amidst an unfamiliar landscape of death and dying

Poppy's simulation experience began with the constipation scenario. Shifting ahead through the scenarios, playing the role of the RN in the dying scene, Poppy found this scene to be "scary" because she had not previously seen someone take their last breath:

Was kind of scary, because **I haven't actually seen someone dying before**, like I've seen a dead body but **I haven't actually seen them take their last breath ...** I didn't notice at first when she [Doris] stopped breathing. (p. 16)

For Poppy, this was another unfamiliar landscape of death and dying, witnessing for the first time, the patient take their last breath, in simulation. However, there is some tension in Poppy's storyline. On the one hand, she said this scene was scary because she had not seen someone take their last breath before. But, on the other hand, she actually did not notice when this happened to Doris in the scenario.

4.15.2.2 Thread 7: Real versus unreal landscapes in simulation (not a real person)

Poppy found that it was hard working with manikins in the simulation because they were not real.

I did find it hard to take care of the simulation **dolls** because they are **not real** ... it is weird because it is made of rubber, it's **not a real person**. Like touching it, feeling for a pulse ... it's different. (p. 17)

Poppy feels simulation in general is not real because of the manikins. However, her storyline bumps up against itself in the previous thread. Firstly, she found the scene scary, suggesting a degree of realism, but in the storied fragment above she found it unrealistic because it was a manikin, made of rubber. This presents two binaries: one of real/not real and one of human/not human and is a conundrum for Poppy. Poppy's comment that the patient was a doll signifies a disconnection and a dehumanisation of the scene; she has no emotional involvement and connection to the patient in the scenario.

4.15.3 Poppy's Intertwining Threads

The unreal nature of simulation (Thread 7) and managing herself amidst unfamiliar landscapes of death and dying (Thread 5) permeate through her stories as she witnesses

death for the first time in simulation. The thread of managing self amidst unfamiliar landscapes links Poppy to James.

4.16 Getting to Know James

Like other participants, I had come to know James, aged 33, at the beginning of his undergraduate degree. At this time in his life he had worked at several jobs including working on a prawn trawler. James at first seemed an unlikely candidate to be a nurse: tall, lanky and clumsy, often referring to himself as the 'class goof'. However, relaxed and friendly, he soon endeared himself to fellow students and academics alike. James soon started to demonstrate a passion for nursing. He excelled in his studies and consistently gained excellent grades across his degree. I was delighted when James came to me to express his interest in my research, firstly, because he was one of my few male students and secondly, because I was looking forward to learning about his experiences.

During the simulation, James appeared anxious. His face and body language during the pre-briefing and throughout the simulation revealed how intense an experience this was for him. During the dying scene video, James is seen to not only stand back but also actually lean back, as if he wanted to sink into the background during this scene.

Moving ahead in time to the participant interviews, James's interview was one of the last undertaken at almost 10 months after the simulation. We arranged to meet at his favourite café in town whilst he was in town visiting his parents. Awaiting his arrival, I was keen to catch up with him and looking forward to learning all about his experiences. James arrived a few minutes later, hugging me like an old friend. It seemed quiet sitting outside under the awning of the café; this was until the lunch time crowds started to arrive. Listening back over the interview recordings, I have to smile at the surrounding sounds of people laughing, babies crying and laughing, and the normal sounds of everyday life – a stark contrast to our topic of discussion.

James seemed to enjoy reliving, retelling and reshaping his stories; these were dotted throughout with chortles of laughter. Often his stories overlapped and interweaved with other stories and, at times, it was hard to keep him on track, with one story leading to another. Our interview was to last one hour and forty-one minutes, the longest of all the interviews undertaken.

4.16.1 James's Background Story

4.16.1.1 Thread 5: Managing self amidst an unfamiliar landscape of death and dying

Initially, James thought he had not seen someone die, but during the interview he remembered the moment that he did see someone dying whilst on clinical placement in an intensive care unit (ICU) in second year. This first experience of death and dying was an unfamiliar landscape for him:

I actually did watch someone die ... and I'd forgotten about this ... freaky ... I remember vividly and they [the nurses] put me at the end of the bed to watch and I remember watching the life just [go] out of her eyes ... I ended up cleaning the body ... and I'm just standing there at the end of the bed and then when I stopped, I think it was **that shock value** ... I just bucketed ... that was one of the most full on things I've ever seen in my life ... it's not like I had an emotional attachment ... and **it just was a freak out moment**. (pp. 11–12)

James's storied fragments reverberate with his ability to manage an unfamiliar landscape of death and dying in the midst of his first clinical experience with death. In this liminal space of time, James actually realises in this moment that he has in fact witnessed death for the first time prior to the simulation. His storylines bump up against each other here: on the one hand, he denied any attachment, however, on the other hand, he still felt the sharp intensity of this experience and reacted to this emotionally when he cried. Although he sees himself as without any emotional attachment, his unguarded reactions suggest otherwise. Looking backwards in time, James is shocked to realise that he had actually experienced witnessing death when previously he was convinced that he had not witnessed that moment in time. I am left wondering how James has not remembered this significant moment and this causes some tension for me. For me, this tension remains unresolved. I think back to my own memorable first death experience and Millie's comment about not forgetting your first death experience and wonder how it is that James had initially forgotten this experience. Is this perhaps because this was such a shock to him, relived through his exclamation of this as a "freak out moment"? Perhaps the intensity of this first experience somehow made him temporarily forget this experience.

James also remembers how he touched the patient during her end of life care:

I remember ... I held her foot and I rubbed ... I think I was a mess, I was in that much shock ... I just rubbed ... that's all I could do ... I was just sort of standing there ... I blubbered and all that afterwards ... that was full on! (pp. 19–20)

The very social gesture of touch is reinforced in James's story, the use of touch also became an unfamiliar landscape for James. In this instance, James found himself instinctively responding in an embodied way by touching and rubbing the patient's foot as she died. This was all that he felt he could do. This act of stroking and rubbing the patient's foot in this instance, although a sign of comfort for the patient, may also have served a dual purpose in providing comfort to him as well, amidst this distressing situation. By doing this, he is crossing boundaries in an attempt to be with this person in their personal landscape. Although this act is one of embodied knowing, it also creates a sense of embodied tension for him that unfolds in his simulation stories.

4.16.1.2 Thread 1: The role of others in shaping death experiences (beautiful)

James relives another end of life experience. This time, it is the first time he saw a deceased person, whilst on first year clinical placement:

I had someone die on my first placement ... the woman who I was with, beautiful nurse, she was like "Today's going to be the day ... and the whole family's here and this could be really, really full on, I don't know how you're going to take it" ... and I handled it so well ... I wasn't there the moment it happened ... and she'd given me that warning, so when I went in, I didn't actually see him like, take his last breath but it was minutes, minutes after I walked in ... **the first time I'd ever seen it**, and ... I sat there and talked to the two brothers ... and **it was so beautiful** (pp. 5–6) ... it literally was like two minutes, I think, passed like he literally stopped breathing ... it just **transitioned beautifully**, it was fantastic, it was really great. (p. 7)

James's experience of seeing a deceased person for the first time was shaped by the nurse he was with, which contributed to a supportive and positive experience for him. The nurse he was working with told him that the patient was going to die that day and helped prepare him for the intensity of this experience. This was such a good experience for James he was even confident to sit with family and talk to them. Similar to Holly, James felt that this was a beautiful experience.

4.16.2 James's Simulation Story

4.16.2.1 Thread 2: Attending to family at the end of life (it was about him as well)

James's simulation story begins with the unconscious patient scene. During the debriefing session, James talks about how his group attended to the family, Doris's son, during this scene:

We asked him how he was, first, because he looked like he was worried. So we asked if you were ok, first ... It wasn't just about her [dying person] ... **It was about him** [her family] **as well.** (p. 17, Debriefing)

In attending to family at the end of life, James and his other group members were able to show that not only was the simulation about Doris, the manikin in this scene, but it was also about him, the son, as well.

4.16.2.2 Thread 5: Managing self amidst an unfamiliar landscape of death and dying (touch)

Playing the role of RN during the dying scene, James found that he wanted to touch participants who were playing the family, but was concerned about crossing boundaries of space and this caused him some tension:

I wanted to, but I didn't know whether I was going to **cross the boundaries** or not. (p. 7, Dying scene)

I would want someone to give me a hug, definitely. (p. 8, Dying scene)

James's use of the word "boundaries" suggests a visual image of crossing personal spaces, crossing borderlands involved in desire to touch. Tension is created in this instance because James wants to provide the person touch, but is unsure as he is a male caring for a female patient. Tension is created because James does not want to cross the boundaries of the landscape of professional practice. Furthermore, this simulation story of touch bumps up against his previous story of clinical practice where James automatically reaches out to the dying patient in ICU rubbing her foot during his clinical placement.

In James's statements, there are stories that bump up against each other creating tension. On the one hand, James says he would want to be touched if he was the person in this situation. However, on the other hand, in the role of RN in the simulation, he is indecisive about using touch. This clash of feelings is grounded by his awareness of professional boundaries as a male nurse. James's indecision is also reflected in his body language, leaning backwards and showing uncertainty. Juxtaposing this is the caring approach evidenced in his communication throughout the dying scene. However, these stories do smooth out in the next section when he mentions he uses touch all the time now.

4.16.2.3 Thread 3: Theory, practice and experience become synergised (reflection)

For James, his first end of life experience was relational to his simulation experience:

It relates, so when you [do] a simulation like that, you do relate back to what you've done ... and you do that **reflection** type thing ... **I reflected straight back** to that one [in simulation]. (p. 7)

The simulation in this instance acted as a conduit to reflection and triggered memories of his clinical placement. The interconnectedness between simulation and clinical placement experiences reverberates throughout this storyline.

Playing the RN in the dying scene alongside Millie, James found that he learned about touch and how this can be applied to clinical practice:

I remember ... I stood on the other side of the bed ... [Millie] walked around and touched ... and it was something that I hadn't seen before... like, you take it as a real experience ... make this as real as you can ... and in my head, now, I think I'd go to the side of the bed ... put myself at their level ... do not stand up ... just go gentle (p. 13), that sim [simulation] really helped ... like touch and that personalisation is a beautiful thing to do. (p. 14)

I want to make this as real as possible because then, it's going to teach me for real life and ... **touching** and getting on that level ... **I do it every time now**. (p. 22)

James was able to use simulation as a real life experience and has taken this learning from simulation into his clinical practice, integrating theory with practice and experience. James felt that the simulation helped reinforce the use of touch, melding the social and spatial elements within the simulation. This is significant because for James touching became a more accepted social and nursing tool. Looking ahead, James mentions the impact that this use of touch in the simulation has had on him, and how he uses touch all the time now: a transitioning through time from simulation to his current clinical practice and looking into his future clinical practice.

James also talks about his experiences following the simulation where theory, practice and experience have become synergised.

On my last prac [clinical placement] ... a palliative patient ... was coming in to have some treatment ... but just to chat to her about that ... it was beautiful and because **I'd been prepared** ... and I think **without the simulation** ... I wouldn't have been confident enough ... for someone with life experience ... this **gives me something**

to relate to and I've got the confidence ... I've been through this ... it makes you that much more confident when you go in to actually real life situations. (p. 9)

Several months after the simulation experience, James's simulation story has now come full circle, from being unsure about the use of touch in simulation to gaining the confidence to talk to patients on clinical placement about issues surrounding end of life, smoothing over past tensions. James believes that without the simulation, he would not have had this confidence.

4.16.2.4 Thread 8: Finding comfort amidst learning and working together

Working alongside his friend, Emily, in the unconscious scene James found comfort amidst learning and working with his peers:

I think Emily kind of guided that, and so it's nice when another student ... that's why I think that group idea and that simulation works ... it's like in your work environment you may not have worked with that RN very much but you go "Right, let's make this work". (pp. 13–14)

Sociality is central to James as he refers to his friend and fellow student, Emily, and how she guided him during the simulation scene. Relating the simulation back to the clinical environment, James makes the link back to working alongside other nurses in clinical practice.

4.16.3 James's Intertwining Threads

James has several key threads of experience that reverberate throughout his stories of experience: unfamiliar landscapes of death and dying (Thread 5); clinical experiences with supportive RNs (Thread 1); simulation synergising theory, experience and practice and the use of touch (Thread 3); finding comfort amidst learning and working with peers (Thread 8); and attending to family in simulation (Thread 2).

James and Emily are intertwined on several landscapes. They are, firstly, interlinked through three threads of experience (Threads 1, 3 and 5); secondly, through the simulation landscapes of travelling alongside each other in their small groups; and finally, closely interwoven within their personal landscapes as close university friends, a friendship that has grown over the three years of their degree.

4.17 Introducing Emily

Like other participants, I had come to know Emily, a mature aged student (aged 43), over the duration of her undergraduate degree. Emily came into my research with a rich background of working in education as well as five years' experience as an AIN as a young woman, adding richness and depth to her stories. Also a very spiritual person with a very strong Christian faith, Emily's background and simulation stories resonated very deeply with her spirituality. I interviewed Emily in my office, approximately 10 months after the simulation experience.

4.17.1 Emily's Background Story

4.17.1.1 Thread 1: The role of others in shaping death experiences (sad and confronting)

For Emily, her first death experience as an AIN was a negative experience, shaped by the nurses she was with:

I couldn't get Mrs. X to have her breakfast and ... the RN ... said "That's because she's dead!" ... [the nurses] gave me such a hard time [laugh] and I just wasn't experienced and it was fine [that I was teased] and they [the nurses] buddied me up with someone to clean the body ... the most distressing thing was that she [the nurse] was so **disrespectful towards the body** and that really **upset me** ... that was my first dead body at 16 or 17... that is probably why I can talk about things ... and it was **sad and confronting** but I can process it quite well. (p. 34)

Emily's fragmented story reveals an unfolding story of her experience that was shaped by her colleagues. This first experience nearly 30 years ago has had a long-term impact on Emily. Thinking about Emily's first death experience, it resonates through me as I, too, am transported to another time and another place to my own first death experience, at such a young age. I find myself comparing our experiences, as both unprepared novices for this first death experience. Although the RNs she was working with used humour to help her through this experience by teasing her, tension is seen as Emily recalls this experience as "distressing". This is because of the disrespect shown towards the deceased, which has shaped this into an ugly and negative experience for her. Although she found this confronting, conversely, she was able to talk through the experience and process it well, resolving some of the tension she experienced.

4.17.2 Emily's Simulation Story

4.17.2.1 Thread 7: Real versus unreal landscapes in simulation (disrupted spaces in time)

Emily's simulation story begins with the unconscious patient scene (Scene 4). Due to the sequencing of the simulation, Emily felt that some aspects of the simulation were not realistic. Emily's storied fragments from the debriefing session reflect her feelings of this:

I think it was hard because we started with the second last [scene] we'd gone with her dying and then come back to that ... we were kind of still in the zone of someone confined to bed, it was just a different zone to get into ... That was just a timing thing, but it was hard in **10 minutes** to get into that ... It was hard because we went backwards. (p. 8)

Disrupted spaces in time and discontinuity of time in the simulation added an unrealistic dimension to the simulation experience for Emily, who was caught up with Doris dying in the scenario, two scenes before this scene (the constipation scene). Emily was thrown by what she felt was moving backwards in time and disruptions across the time continuum. Going from the final scene early on in the simulation gave her a sense of going in reverse. Although, to Emily, this felt like moving backwards in time, the scenes always progressed in a forward motion across time, but were out of sequence for Doris in her disease progression.

This highlights a significant consideration within simulation experiences that temporality and spatiality of the simulation are important driving factors in simulation when dealing with multiple scenes that have a definitive progression from one scene to the next. The sequencing of scenarios needs to be in such a manner that students can progress through in a normal manner.

Contrasting with the previous excerpt that sequencing made the simulation unrealistic, Emily, in the following excerpt, found the presence of actors added to the simulation realism, linking her to her own personal experiences. Playing the role of family in the dying scene became quite real for her because she recently experienced death and illness of close family members:

Because death and dying is quite emotional, there was **a real benefit** in having an ongoing stage by stageness [sic] of it ... these relatives were being quite anxious and ... my grandmother had died a couple of years before, but it was very close to home. ... We then go into the death and dying [scene] and ... I played it [role of family] quite strongly and **I had real tears coming down my face** asking "Is she dying now?" ... I was acting it but at the same time it was raw because it was like my grandmother's death just all over, poor James feeling like he made me cry ... there's a benefit in

actually having that so strong and so powerful and you get that from going from one stage to another ... I saw myself (p. 6) ... you do [situate yourself within that role] because ... my mother had recently had a heart attack ... so it was kind of “This could be me, this could be me” (p. 7) ... if I actually had it in order (p. 7) ... It could have been in some ways quite a lot more powerful (p. 8) ... it got me because ... you know what **it is like to be in that situation yourself**. (p. 8)

The emotional nature of death and dying is felt across all contexts of care. Clinical, personal and simulation are relational and intertwined. Time, place and social dimensions also interconnect. Across the continuum of time, the unfolding in stages of the scenarios impacts on Emily’s simulation experiences. The emotionality of the simulation on death and dying reverberates in her own personal experiences as she has a deep feeling and strong connection within the simulation. There is a sense that Emily has placed herself back in time and place when her grandmother was passing away. Drawing upon her personal experience, she is drawn closer into the simulation experience showing anxiety of the relative whilst playing the family member. Emily is so drawn into this experience that she finds herself actually crying during the scene. Although her emotions suggest reality within the scenario, tensions arise from the simulation sequencing where there is a juxtaposing of reality and unreality in the simulation.

Emily found that the dying scene was even more profound for her because of her recent personal experiences with her grandmother’s death and her mother’s recent illness, the spatiality of the simulation room reminding her of her recent experiences.

I think it is a lot to do with that sim [simulation] room because you are in this enclosed environment and **it really feels like a hospital room** ... And the lab [laboratory] just feels quite normal ... Whereas the sim [simulation] room ... **feels very ICU** [Intensive Care Unit] ... kind of locked away and you felt more, I felt safer to be able to play that part ... I am an aesthetic [sic] so I am very aware of my surroundings. (p. 9)

Emily’s comments reflect the difference between the environment of the clinical laboratory spaces and the simulation room that makes the simulation real versus unreal. For Emily, the simulation laboratory (set up to look not only like a hospice room with comfy chairs, dim lighting, flowers by the bedside and a homemade patchwork quilt but also all designed to make this space feel like a bedroom rather than a hospital room) became a safe place and private space to become immersed in the simulation in comparison to the other clinical laboratory spaces. I am wondering whether this has had an impact on Emily and her perceptions of the differences between these two clinical spaces.

Emily’s storied fragments here bump up against Bree’s storyline of the space not being realistic. For Emily, being in the simulation room is what made that scene the most realistic.

Within this space (enclosed environment) she feels comfortable and safe, and that enables her to play the part of the family member so realistically, making this a realistic landscape for her. However, like Bree, Emily feels that the clinical laboratory spaces are a more unrealistic landscape.

4.17.2.2 Thread 3: Theory, practice and experience become synergised

One of the important lessons learned through simulation by Emily is in relation to questions asked at end of life and how to deal with these in clinical practice:

Trying to see what the concern is behind the question for relatives and patients because it might be that they have asked something strange or confronting, but it is actually because they want to talk about the fear, and they don't know how else to raise it (p. 47) ... it is probably something I have learnt over the years, too, but people's comments or questions are not always what they seem ... You need to look at why they are asking the question ... I certainly think the sims [simulations] are really, really, great learning, role modelling and role playing experiences, so that makes you think about your behaviour and your thinking (p. 49) ... seeing people for where they are at ... how do I support them. (p. 50)

The crossover here from simulation to clinical experiences resonates in her discourse where theory, practice and experience have become synergised. For Emily, what might seem to be a strange question to ask in theory, might actually signify a fear the person needs to have addressed in practice. She has found through experience that sometimes the person's questions are not always what they seem, as she attempts to answer this in the simulation scenario and apply her experience with theory and practice. Emily tries to see what the concern is behind the question, in between these liminal spaces, delving deeper to find the hidden message. She felt that the simulations are not only great ways of learning, but also helped her to connect with her own inner feelings and behaviours with the simulation forming a bridge across her experiences and feelings, and linking theory, practice and experience.

4.17.3 Emily's Interlinking Threads

Important threads in Emily's stories included the role of others in shaping death experiences (Thread 1), the real versus unreal landscapes of simulation (Thread 7), and finally how theory, practice and experience have become synergised (Thread 3). Similar to James, Emily is interlinked with David on different landscapes, firstly, through Threads 1 and 3, and secondly, as close friends amidst their university landscapes.

4.18 Getting to know David

David was the first participant to volunteer for my research. I had met David the year before when he was enrolled in another unit of study. However, I did not get to know him until he approached me to participate in this research. David, a mature age student, aged 36, had a lifelong desire to become an RN. During the time that I got to know David, he revealed himself to be a dedicated family man who was easy to get to know and widely liked and respected by his fellow nursing students and staff alike.

Prior to the simulation, David had been working as an EN for approximately three months and as an AIN for approximately three years prior to this. As a mature aged student, David also brought to the simulation an array of experiences including working part time in the anatomy laboratory of the university. Although, the first to volunteer for my research, David was the second last of the participants to be interviewed, just under 10 months after the simulation. On the day of the interview we met at a local café, but finding the café to crowded and noisy we moved to a nearby park, since it was a lovely late summer day, to complete the interview.

4.18.1 David's Background Story

4.18.1.1 Thread 1: The role of others in shaping death experiences (walking through the experience together)

David's background story begins with his first end of life experience as a first year student nurse on his first clinical placement. In attending to his first post mortem care, David found the nursing staff very supportive. Even though David felt his first death experience was new to him, he found that he was well supported by the RN:

With an RN... they [the RNs] were really good ... **they just walked me through** every single thing that was happening and why it happens (p. 20) ... and just watching how they [the RNs] dealt with them [the family] they were pretty amazing (p. 21) ... more respect around it ... a really good experience, a great RN. (p. 22)

In this storied fragment, David talks about his first clinical death experience and attending to after death care as being one that was very much supported, and the importance of having other experienced nurses who have shaped his experience with end of life care. He found this to be a good experience because the RN walked through this with him and explained everything along the way, travelling alongside him on his first journey of experiencing end of

life care. I am given a sense that David was in awe of these nurses and how they showed exceptional care toward the family at this difficult time of life.

4.18.1.2 Thread 5: Managing self amidst an unfamiliar landscape of death and dying

For David, his first experience with a deceased person, in his first year, first clinical placement, was not so much frightening, but more an issue of not knowing what to do amidst the unfamiliar landscape of death and dying. This was also David's first experience with seeing someone take their last breath. When asked how this was for him, he responded with some uncertainty:

It is upsetting but it didn't worry me ... It was more the nerves about what I had to do in that situation like preparing the body because that was all new to me ... That was probably my biggest fears ... it was more not knowing what I was doing ... (p. 20) I don't know if I knew how to react, was probably the big thing. (p. 22)

Although during this first unfamiliar experience with post mortem care, David finds the experience a little upsetting, he is also pragmatic, taking the experience in his stride as a fact of life. However, his pragmatism is juxtaposed with his anxiety about what to do in preparing the body after death. His feelings here are more about a fear of the unknown, not knowing what he is doing and not knowing what to expect.

4.18.2 David's Simulation Story

4.18.2.1 Thread 1: The role of others in shaping death experiences (playing role of son close to home)

David's simulation experience begins with the nausea and vomiting scene. Playing the role of the son in the dying scene, two scenes later, he throws himself into this scene. During David's interview, he reveals why playing the role of the family member is significant for him as he reflects on how the nurses helped him through this personal experience of his father's death, as a second year student nurse:

My dad passing away ... that was a big thing (p. 23) ... I was there for most of it ... and spent a lot of time just by his bedside ... one of the nurses said to me ... "He doesn't want to go while you are here ... from the stories you have told ... he is not going to want to die while you are here" and that is how it happened (p. 24) ... that is probably what made it slightly emotional or easier to fall into the place of the family

member [in the simulation dying scene] ... because **I sort of did that** ... [playing role of family member] it's probably therapy. (p. 25)

Although discussion here is on clinical placement experiences, David relates back to a very personal experience that occurred with his father dying and the support shown by nursing staff attending at the end of life. David's personal experience with the death of his father intertwines with his simulation experience in the dying scene as he reflects on how emotional this simulation experience is for him.

David's simulation experiences are also intertwined, melding almost seamlessly not only across time but also across situations and across personal landscapes. Sociality is further reflected in David discussing the emotionality of playing the role of the son in the simulation. He found the simulation experience was easier because he had already been through a similar experience when his father died. Temporally, David is comparing this personal experience from several years ago with the recent experience of the simulation several months ago. For David, this was a therapeutic experience.

4.18.2.2 Thread 4: Managing self amidst negotiating difficult conversations at the end of life (what do you ask?)

Like others, David talks about his nerves, going into the simulation and how these are due to the unknown elements within simulation and managing difficult conversations from the perspective of the family member in the dying scene:

Nervous ... I think it was just the unknown and not knowing how the dummy was going to respond or what was actually going to happen ... not knowing what was going to happen and when ... What questions I should ask ... As a family member... Because **what do you ask?** (p. 9) ... Generally, there's a standard reaction from a lot of things like, like with pain there's generally a process to follow but end of life, well ... it is the unknown, basically ... Reactions to end of life ... it helps as far as actually having to deal with it. (p. 10)

David's experience in this instance is different to others, wondering about what questions to ask, juxtaposing with other participants as they were confronted with not knowing how to respond to difficult conversations. David once again reflects on the uncertainty of end of life simulation and what to expect as the scenes unfolded. Socially, this is even evident playing the role of the family member as is uncertainty evident as he contemplates what to ask. Further reinforcing this uncertainty is that David feels that in some situations, there are certain reactions that you can expect, but comparing this to end of life he feels that responses at this time are not normally as predictable. However, his final statement smooths out some of the

tension of not knowing what to say, as he finds that the simulation is helpful in preparing for how to respond in real life.

4.18.2.3 Thread 3: Theory, practice and experience become synergised

Providing end of life care, clinically, after the simulation, as an EN in the local hospital, David is able to reflect back on the simulation experience with Doris in an effort to improve end of life care in real clinical settings. David provides an example of how thinking about the simulation made him think differently during this recent clinical experience.

We got a palliative patient so it made a big difference having a little bit of an idea as to what is going to happen and what to do (p. 18) ... because we didn't do palliative, it was surgical ward ... no one really knew what to do, especially when ... the family started asking what was happening ... and the first thing that kicked into my mind was we need to look after these guys ... just trying to get a comfortable environment for them ... Because we didn't have that set up there anywhere ... (p. 22) they didn't know what was happening. Basically just try to provide a calm environment ... obviously there is going to be an end point and **I did think about the simulation** and go "Right, these guys have got nowhere quiet ... to ask the questions and find out what is happening" they haven't got the privacy they require ... which now that I think about it, the way the sim [simulation] is run, it is put in a totally separate room ... which makes it a bit more pleasant ... and time to talk to them and making the time ... for them (p. 23) ... I worked on a surgical ward where you don't deal with it and **I think if we didn't do the simulation**, yeah, we would probably have, almost have, just the room alone, almost [sic] ... **I think it [simulation] helped a lot, definitely.** (p. 24)

David's discourse shows how theory learned from the simulation can be applied and integrated into clinical practice. Space is important here as David talks about his own clinical practice where he works at the local hospital in a surgical ward. Reflecting back in time, David found the simulation was helpful and made a difference for him and consequently for the palliative care patient and their family. He found he was able to apply his learning and knew what was going to happen and what he needed to do in this situation and he found this was relational to the simulation experience several months earlier. Reflecting back to the simulation, David realised that the environment was important and that family members needed a comfortable and quiet space to grieve and manage themselves. Thinking back to the Doris scenario in the simulation, he remembered that she was cared for in a single room and how this made the dying scene more comfortable. The action of dying became private. For David, family members asking difficult questions was similar to what unfolded during the

dying scene in the simulation. Time once again becomes central as David talks of the family needing time to talk and, as an RN, making time for the family. Summing up this experience, David felt that the simulation helped him prepare for and manage this situation, reinforcing how the simulation was relational to clinical practice. I am left wondering about the impact that these experiences will have on David's future practice as an RN.

4.18.3 David's Intertwining Threads

The overarching thread for David is managing himself within difficult conversations (Thread 4) and unfamiliar situations (Thread 5) at the end of life. The role of others in helping shape positive end of life experiences (Thread 1) is also significant for David. David's feelings of uncertainty have now come full circle, as he travelled firstly from uncertainty to certainty after his simulation experiences where he is now able to apply learning from simulation into clinical practice (Thread 3). David is interlinked with Ashley by Threads 4 and 5.

4.19 Introducing Ashley

I first met Ashley, aged 32, on the day of the end of life care simulation. Ashley volunteered to undertake my research about two weeks before the simulation, contacting me by email. Ashley came into the research with lots of nursing experience, acknowledging that she was an AIN for two years before undertaking her enrolled nursing degree approximately eight years ago. At the time of interview, Ashley was employed full time as an EN in the Emergency Department of a hospital in Western Sydney where she had been working for several months. As an EN, she has specialised in paediatrics and anaesthetics. Ashley has identified herself as an Australian who has Anglo-Celtic and Eastern European heritage. On first meeting Ashley, I was impressed by her energy and positivity. She struck me as someone who throws herself into her work and university life with full capacity. During her interview, Ashley provided me with a wealth of experience and knowledge, someone who shows obvious passion for her work and studies.

Organising Ashley's interview was a little challenging. After several emails, we agreed to meet in the eastern suburbs of Sydney at a small café opposite the Prince of Wales Hospital. Ashley suggested this spot because she recently worked at the hospital and this was one of her favourite cafés. I interviewed Ashley 10 months after the simulation session.

The day was so beautiful, we decided to take a bench seat outside in the sun. This was a long interview with Ashley, which lasted around one hour and forty minutes. I found that she continued to talk freely throughout, even with a physical move to a spot outside, under shelter when it began to rain after a sudden change in the weather.

We sat outside at a wooden table, surrounded by potted herbs mounted along the walls. Tucked away at the side of the café, we watched the busy Sydney traffic and people as they briskly walked past going about their normal working day lives. Once it began to rain, we moved around the corner to an undercover table in front of the café. This was an interesting spot where busy pedestrians passed by in multitudes. Being so close to the hospital it was inevitable that traffic included ambulances flying past with sirens blaring, adding to the context of life passing by us.

Later, after the interview, I sat down at my hotel and jotted down my reflections on Ashley's interview, as I had done for all other interviews. This being the final interview, I found I was able to write freely my feelings and reflections on this interview. I felt very privileged having participated in Ashley's interview, as she had so much to share with me during this time and gave so much of herself freely. I feel very lucky to have been invited to share Ashley's memories of her experiences, some very personal; this has been a very humbling experience for me. As my final interview, I also felt very glad and relieved that they were now finished, allowing me to then focus on the job of transcribing and analysing.

4.19.1 Ashley's Background Story

4.19.1.1 Thread 5: Managing self amidst an unfamiliar landscape of death and dying (surreal)

Reflecting back on her own clinical practice, Ashley talked about her first death experience with her very first patients as a trainee AIN when she was 20 years old:

It was the first lady I ever gave a sponge bath to ... I had seen a dead body before, [but] it was my first real one at work ... I'd seen my grandpa in a coffin and ... he looked like plastic ... so he didn't kind of look ... real, I was in my early teens and it was kind of **surreal** ... my grandfather in a coffin but it looked like a wax dummy, like, I was scared and I was like, slowly walking up ... didn't want to see too much and then I was like "It looks just like a dummy, he doesn't look real"... but this lady was the first kind of natural ... dead body ... (p. 19) because I was young ... I said "Do you mind if I just look from the doorway?"... so I didn't stand real close ... she was my first patient I ever took care of, ever. (p. 20)

Ashley relives two unfamiliar death experiences, the first, her deceased grandfather when she was a teenager, and the second, her first deceased person in clinical practice. Both these experiences are unfamiliar because they are both very different experiences in different contexts, where Ashley contrasts these as looking real versus not real. Looking backwards several years in time, Ashley's first clinical experience with a deceased person caused her

to reflect on seeing her deceased grandfather; saying that her grandfather didn't look real made this a surreal experience for her. This feeling of her grandfather looking like a wax figure is relational to and resonates with experiences with simulation and manikins, creating the binaries of real versus unreal and subject (person) versus the body in death becoming the object (like a dummy). Shifting forwards in time from her grandfather's death to her first clinical experience, Ashley compares these experiences. The binary of real versus unreal is further highlighted in this comparison when she mentions that this was her first "natural" dead body which was more real to her than seeing her deceased grandfather.

4.19.2 Ashley's Simulation Story

4.19.2.1 Thread 6: Defining moments in time (disruptions in time)

Ashley's story of her simulation experience begins with the pain scene. Although Ashley began her simulation journey from beginning to end, entering into the simulation with the first scenario and progressing through in the correct order, finishing with the dying scene, she still found that, at times, in Doris's story, she did not know where she was in the story and that became a defining moment in time.

As the scenes unfolded, Ashley became confused within the different scenes:

Just getting **thrown by the different scenes** and not knowing **where we were in the story**, but at the end of the day the patient's going to die. I found it a little **bit rushed** and just the whole **not knowing where we were in the story** with the different scenes and ... so, fast forward 20 minutes, what are you going to do now?
(p. 15)

Defining moments in time, for Ashley, are surrounding her feelings of being lost in Doris's story and a sense of being rushed. This feeling of being "thrown by the different scenes" and unsure of "where in the story" is a strong thread throughout her storyline as she repeats this in a similar vein throughout her stories of experience.

4.19.2.2 Thread 4: Managing self amidst negotiating difficult conversations at the end of life (humour)

Playing the role of the RN in the nausea and vomiting scene, when the patient asked "Am I dying?", Ashley felt caught off guard and did not know how to respond to this difficult question, despite her vast experience with dying patients:

Did I say something stupid, a bit light-hearted? **“Not today”** or something [small laughs] ... we were **just so caught off guard** ... I was like **“Not on my shift”** ... or something inappropriate [laughs] ... probably because **I was taken aback by the question** and because you’re working through the sim [simulation] real fast ... if I had a bit longer to talk with her, I would try to develop a rapport ... ask her ... “What are you worried about?”. (p. 12)

Ashley found she was surprised by the difficult question in the scenario and resorted to the use of humour to get herself through the scene. Looking inward, Ashley can vividly recall what she was thinking and how she reacted during this scene, painting an elaborate image using powerful terms such as she “was taken aback” and “caught off guard”. In the confusion of this unexpected question, Ashley reacts initially by saying something light-hearted. Interestingly, Ashley has had lots of experience with end of life care, yet, despite this, she was still at a loss for what to say because they were working through the simulation fast, not having time to think on their feet. For Ashley time passing quickly during the simulation scenarios contrasts to how she responds in clinical practice. Here we see the interweaving of feeling caught off guard because of time constraints of the simulation and the contrasting landscapes of simulation and clinical practice.

4.19.3 Ashley’s Intertwining Threads

Intertwined throughout moments of time (Thread 6) of not knowing where in the story she was at, are threads of negotiating difficult conversations at the end of life (Thread 4) and managing self, amidst the unfamiliar landscape of death and dying (Thread 5). These are all threads that link Ashley to other students (Threads 4 and 5 link her back to David and Thread 3 links her to Simon, the adjoining quilt blocks, see Appendix N).

4.20 Summary of Findings

Students’ stories of end of life care and end of life care simulation are layered with stories of remembering and encounters of forgetting. Each student’s story resonates with remembrances of their own first experiences with end of life care. However, for some students’ their stories show how some end of life experiences can easily be forgotten. This is seen in James’s storyline where he encounters forgetting his first death experience on clinical placement.

In retelling students’ stories, I too am called to remember my own first experiences with end of life care. Like many of my participants, my own story, too, has come full circle from my own tentative beginnings with end of life care, shifting across time and travelling across

multiple situations and contexts, culminating with end of life care simulations and leading me to my research.

In this chapter, storied fragments of individual participant experiences with end of life care and end of life care simulation have been explored. In accordance with Clandinin and Connelly's (2000) three dimensional framework and Dewey's (1938) criteria of experience, participants' stories were presented in order of temporality across a continuum beginning with background stories of experiences before the simulation, culminating in stories with end of life care simulation.

As participants' storied fragments unravelled, at times these travelled alongside and overlapped with other participants' storied fragments, sometimes causing tension and at other times smoothing out experiences and giving a sense of coherence. Each participant's storied fragments revealed a range of threads that captured the essence of their experiences (Appendix M: Table of Threads). Threads revealed the importance of the role of others in shaping end of life experiences (Thread 1), how theory, practice and experience become synergised (Thread 3), and how students managed themselves amidst the unfamiliar landscapes of death and dying (Thread 5). Other threads of significance provided insight into how students managed themselves amidst difficult conversations on the end of life (Thread 4), and how moments in time defined their experiences with end of life care, looking toward the future (Thread 6). Threads also of relevance to participants' experiences were, finding comfort amidst learning and working together (Thread 8), attending to family at the end of life (Thread 2) and finally, entering into real versus unreal landscapes of simulation (Thread 7).

Overlapping and interlacing stories reveal commonalities and singularities of experience that provide a deeper perspective and insight into the experiences of students and what these mean for end of life care experiences and end of life care simulation. These are explored in the next chapter (Chapter Five).

Chapter Five: Discussion and Conclusion

5.1 Introduction

As I sought to unpack my research puzzle and piece together the fabric of my quilt, of understanding undergraduate nursing students' experiences with end of life care, end of life care simulation and the impact of these experiences, I unravelled a number of overlapping stories that revealed threads of students' experiences. Eight resonant threads of significance identified from students' experiences and explored in the Findings chapter are: Thread 1: The role of others in shaping death experiences; Thread 2: Attending to family at the end of life; Thread 3: Theory, practice and experience become synergised; Thread 4: Managing self amidst negotiating difficult conversations at the end of life; Thread 5: Managing self amidst unfamiliar landscapes of death and dying; Thread 6: Defining moments in time; Thread 7: Real versus unreal landscapes in simulation; and Thread 8: Finding comfort amidst learning and working together. These threads intertwined and interweaved together across various participants, linking them together in their experiences like a metaphorical patchwork quilt.

Dewey's (1938) philosophy of education based upon a philosophy of experience and Clandinin and Connelly's (2000) three commonplaces of narrative inquiry underpinned this study, where life, education and experiences are inextricably linked. Continuity of experience (Dewey, 1938) and the commonplace of temporality (Clandinin & Connelly, 2000) resonate throughout participants' experiences along a continuum of time where each experience lives on in future experiences of participants. The criterion of interaction (Dewey, 1938), and the commonplace of sociality (Clandinin & Connelly, 2000) and the influence of others on these experiences also resonate throughout participants' stories. The criterion of situation (Dewey, 1938), and the commonplace of spatiality (Clandinin & Connelly, 2000) with experiences occurring across a wide variety of landscapes and contexts are inseparable from the criterion of interaction (Dewey, 1938) and sociality (Clandinin & Connelly, 2000).

I continue to live within these three dimensional narrative inquiry spaces, interwoven and interconnected within these final research texts of this, the final chapter of my thesis. Field texts are interlinked, and discussion and analysis of the final threads of students' experiences are synthesised within the current available literature in this chapter. As a relational methodology, I am co-constructing, with the participants, a narrative of the phenomena of students' end of life care experiences.

In this chapter, participants' stories of experience intercept, intertwine and overlap. Overlapping stories of experience are revealed through a binary of commonalities and

singularities of experiences. I present these commonalities and singularities of students' experiences under two umbrellas that address my research puzzle and research aims:

- 1) Discourse of Death and Dying
- 2) Transformative and Translational Landscapes of End of Life Care (Personal, Professional, Simulation)

To conclude this chapter, I discuss the strengths and limitations of my research, I then draw on my research findings and discuss implications and recommendations for end of life care education, simulation and clinical nursing practice, and propose direction for future research. Finally, I include my personal reflections on my PhD journey and provide my thesis conclusion.

5.2 Part 1: Discourse on Death and Dying

5.2.1 The Death Taboo Discourse

Discourse is defined as “Forms of spoken interaction, formal and informal and written texts of all kinds” (Potter & Wetherell, 1987, cited in Parker, 1990, p. 189). Additionally, discourse is regarded as patterns of ways of representing a phenomenon in language (Crowe, 2005; van Dijk, 2005), and a way of constituting knowledge within social practices, and embodied, constituting the nature of the body (Foucault, 1983, cited in Diamond & Quinby, 1988). Discourses are derived from power, an intrinsic part of all relations, considered to be both cause and effect, and often possess ‘hidden’ power (Foucault, 1983, cited in van der Riet, Higgins, Good, & Sneesby, 2009).

Like Clandinin and Connelly’s (2000) narrative inquiry and Dewey’s (1938) criteria of experience, discourse is considered to be three dimensional in nature. Socially, discourse is constructed of texts and represented in language (van Dijk, 2005), understood by the context in which it occurs (situation) (Crowe, 2005), and occurs over a specific time (temporal). All three dimensions of discourse are revealed in participants’ storied experiences of end of life care and end of life care simulation.

We make sense of death through social discourse (Hedtke, 2002). However, a discourse on death and dying is often surrounded by silence (Llewellyn et al., 2016; Osterlind et al., 2016), suggesting that death is a taboo subject (Adorno, 2015; Coombs, 2014; Lakasing, 2014; Nyatanga, 2016; Queded & Rudge, 2003; Wise, 2012; Zimmerman & Rodin, 2004). This death taboo discourse has a long history dating back through time to the 16th and 17th

centuries through the writings of Frances Bacon and René Descartes (Callahan, 2000), however, it may be as old as life itself.

The death taboo discourse is often propagated by the medical profession (Llewellyn et al., 2016), where death is increasingly medicalised (Malone, Anderson, & Croxon, 2016). Curative measures and aggressive therapies, such as cardiopulmonary resuscitation (CPR) and life support technologies, have changed the face of death with a shift towards extending and preserving life (Banjar, 2017; Salum et al., 2017), giving hope that death can be conquered (Lakasing, 2014), or alternatively that death is viewed as a measure of failure (Banjar, 2017). Using the metaphor of war, death is seen as the enemy to be fought to the very end using all the technology available to combat death (Granda-Cameron & Houldin, 2012).

Further cultivating this death taboo discourse is a death denying discourse. Western society is largely described as death denying (Coombs, 2014; Endrizzi, Bastita, Palella, Cossino, & D'Amico, 2014; Llewellyn et al., 2016; Rawlings, Tieman, Sanderson, Parker, & Miller-Lewis, 2017), or 'dying denying' (Cotterell & Duggleggy, 2016). Conversations surrounding death and dying are said to be rejected, evaded, rationalised, hidden, banished (Banjar, 2017), negatively characterised, marginalised, avoided altogether (Schou, Alvsvag, Blaka, & Gjengedal, 2008), rendered invisible (Cotterell & Duggleby, 2016) or sequestered from public view (Schou et al., 2008).

Importantly, death discourse is shaped by language. Language shapes how we construct and make sense of our experiences (Crowe, 2005). The use of objectifying language such as 'dead body' further shapes the death and dying discourse. This objectifying language is seen in some students' (Simon, Poppy, Emily, Ashley) stories where they refer to the deceased patient as a 'dead body', and not the more humanising 'dead or deceased person'. This objectifying and disembodied language is also seen in the literature where the body, by its nature, can be a subject and an object (Bergum, 2003), silent and passive (Gadow, 1984; Huang, Chang, Sun, & Ma, 2010; Quested & Rudge, 2003), often referred to as 'the case', 'the deceased', or 'the body', and the body as an 'it' (Sakalys, 2006). This discourse surrounding the deceased as the 'body' shapes the way professionals go about managing death (Bordieu, 1977, cited in Scott, 2013), this depersonalisation and disembodiment is perhaps used as a coping mechanism, further perpetuating a death taboo discourse.

The literary device of euphemisms is often used in an attempt to soften death and as a means of speaking openly about taboos or difficult subjects (Isaacs, Isaacs, & Fitzgerald, 2015). Euphemisms used by the students (Holly, Luke, Renee, Sarah, Lauren, Poppy and James) as they retell their end of life stories include 'passed away' and 'passed', instead of 'died' or 'dead'. Not surprisingly then, the most common euphemisms seen in the literature and in

society are 'passed on' and 'passed away' (Isaacs et al., 2015; Rawlings et al., 2017). However, euphemisms such as these suggest a continuum rather than finality (Isaacs et al., 2015). Although such language is used in a caring way, society and health professionals alike use such language because death and dying are taboo and denied and they fear the impact words such as 'death, dead or died' can have on people. The language used shapes the way death and dying are viewed and has the power to construct the reality of death and dying, further reiterating the relationship of power in the death discourse.

Amidst the discourse on death are discourses of humour. Humour is described as a social phenomenon and is widely recognised as a "constructive, therapeutic intervention" (Chiang-Hanisko, Adamle, & Chiang, 2009) that is commonly used in clinical nursing practice as a way of relieving stress or tension (Chiang-Hanisko et al., 2009; Christopher, 2015; Claxton-Oldfield & Bhatt, 2017; Haydon, van der Riet, & Browne, 2015; Mooney, 2000) and coping with difficult situations such as death and dying (Osterlind et al., 2016). Discourses of humour were used by some students (Ashley and Millie) in the simulation when they became 'unstuck', responding to the difficult question of "Am I dying?" (the nausea and vomiting scene). For example, Ashley and Millie both used dry humour ("Not on my shift!") to diffuse the tension experienced during this scenario. Humour used in this situation may have been one means of reasserting a sense of control (Christopher, 2015) or a sense of power within this discourse.

Interestingly, those participants who responded with humour were the most experienced in nursing, each having many years of clinical practice as either an AIN or EN, therefore, interlinking with Dewey's (1938) criterion of continuity of experience, or existential continuum. The nature of previous experience of these participants shows how every experience takes up something from past experiences and modifies to some extent the quality of experiences to come (Dewey, 1938). This is shown in how participants had the confidence to draw on previous experiences and respond with humour. What is particularly evident is that previous experience has a direct influence on the level of humour used in clinical practice (Rosenberg, 1991, cited in Christopher, 2015).

Further perpetuating a death denying and death taboo discourse is the portrayal of death in the media. Binaries of death abound in the media, where death is juxtaposed as violent (news media, movies) or glamourised and romanticised (teen novels, art, celebrity deaths) (Coombs, 2014). Media representation of death has significant power to shape the death and dying discourse and is seen to possess "extraordinary power to interpret death for us" (Walter, 1991, p. 303). This is seen in Holly's discourse that media influence society's perceptions and expectations of death and dying. Juxtaposing this power is Holly's beautiful or 'good death' experiences that are contrasted with the media's portrayal of death. According to Foucault (1983, cited in Pinkus, 1996), alternative discourses such as 'good

death' offer the contestation of hegemonic practices; in this way, the good death discourse challenges and resists death denying and death taboo discourses.

From the students' perspective from this research, death and dying discourse is defined as interaction focused on the phenomena of death and dying, in personal, clinical and simulated contexts. From this study, a discourse on death and dying, revealed in participants' storied experiences, defines how these students shape and construct their beliefs, values and attitudes towards death and dying and, in turn, shape how they provide end of life care. Central to students' discourse on death and dying are discourses of embodied 'good death' and disembodied 'bad death' experiences.

5.2.2 Discourses of Embodied Good Death and Disembodied Bad Death

End of life care, juxtaposed as embodied good death and disembodied bad death experiences, reverberates throughout the students' stories of end of life care and end of life care simulation, where death is a socially constructed phenomenon (Kellehear, 2007; Quedsted & Rudge, 2003). The sociality of death and dying intertwines relentlessly throughout the text as participants shared their experiences. Death is possibly one of the most social experiences of life (Johnson, 2003) often shared by many, in which the meaning of death is co-created by the individuals who share in these experiences (Johnson, 2003). The social construction of death is also formed by personal experiences (Salum et al., 2017). However, death can also be a lonely experience for the patient dying alone or even the inexperienced student nurse trying to cope with their first death experience highlighting social and political realities and the injustices and inequities of death and dying. The act of dying, therefore, has the potential to influence nurses and others who care for the dying, and the nature of care that they provide to the dying in the future (Johnson, 2003). Because death is a socially constructed phenomenon, the care provided by nurses, within socio-political and institutional contexts has the power to shape experiences into either good death experiences or bad death experiences, potentially creating inequities of experience.

As Clandinin and Connelly (2000) pointed out, experience needs to be understood within the social and cultural factors that affect experience.

The concept of embodiment is widely accepted as evolving from philosopher Merleau-Ponty who felt "that every person was uniquely embodied and that embodiment was the existential condition of being a person" (Merleau-Ponty, 1962, cited in Barbour, 2004, p. 229), and is central to our sense of being (Waskul & van der Riet, 2002). Merleau-Ponty's definition of embodiment influenced by time, space, and person overlaps with Dewey's (1938) criteria of experience (continuity, situation, interaction) and Clandinin and Connelly's (2000) three

commonplaces of temporality, spatiality and sociality. Merleau-Ponty's concept of embodiment is along a continuum, lived moment by moment, from beginning to end (Mason, 2014). The person transforms a situation or experience and meaning is created from interaction with the environment (Mason, 2014). Embodiment is viewed as an "avenue for knowing the world through our bodies" (Merleau-Ponty, 1962, cited in Wilde, 1999, p. 25) that resonates with the participants' experiences with simulation through their use of touch.

Through touch, whether through skin-to-skin contact, eye contact, or being present in the moment conveying positive emotions to patients and families (Kautz, 2013), nurses demonstrate caring and compassion; it is considered a gift (Gadow, 1984) and is perhaps the most powerful of the non-verbal methods of communication (Perry, 2005). Touch is the most fundamental feature of human experience (van Manen, 1999). Touch has also been described in terms of intimacy and a privilege (Lawler, 1991) and, in the case of touch, the toucher is always touched (Grosz, 1994; Perry, 2009b).

The physical act of touching was important in the simulation. For Renee, touch provided a flesh-to-flesh experience, and Emily used touch in a reassuring way during the nausea and vomiting scene. However, for some students the use of touch became a conundrum. James, as a male nurse was conscious of touch and space. In the simulation, James was ambivalent about the use of touch, he did not want to cross boundaries as a male nurse. However, he also acknowledged that if that was him in that situation he would want to be touched. For James, the use of touch was risky and open to misinterpretation, not only because of his gender but also because of the risk of increased anxiety for the patient within a culturally non-touching society (Lawler, 1991). Despite the plethora of literature on simulation, there is no current literature, other than this research, that explores the use of touch in simulation and adds new knowledge on this phenomenon.

For some students (Claire, Emily, James), the embodied use of touch was an important social aspect of care at the end of life that contributed to their concept of a 'good death'. However, society holds an idealistic view of what a 'good death' entails. This has been of particular importance for nurses and for nursing practice at the end of life. One of the most widely accepted definitions of a 'good death' is the palliative care approach with a focus on "achievement of the best possible quality of life of patients and families" (World Health Organization [WHO], 1990, p. 11) through prompt identification and management of physical symptoms, and psychosocial and spiritual needs (WHO, 2018). The literature predominantly describes a 'good death' from the medical perspective (Institute of Medicine, 1997, cited in Hold, 2017), patients (Cavaye & Watts, 2010; Cottrell & Duggleby, 2016), health professionals (Cottrell & Duggleby, 2016) and RNs (Costello, 2006). However, there is limited literature on what a 'good death' means to nursing students. Only three sources provide a glimpse into student nurses' perceptions of a good death (Adesina, DeBellis, & Zannettino,

2014; Edo-Gual, Tomas-Sabado, Bardallo-Porras, & Monforte-Royo, 2014; Fabro et al., 2014), however, this literature does not provide students' perceptions or experiences in-depth.

In contrast, this research adds a greater depth of insight and is the first comprehensive qualitative research to clearly define the nursing students' perceptions of a 'good death' as seen uniquely in the positive language and the discourse used to describe death experiences. A 'good death' from the perspective of students included: the importance of touch to portray a sense of travelling alongside the person on their journey and sharing the experience with patients and families (Holly, Renee, James); ensuring dignity in end of life care (Holly); being respectful toward the patient (Holly); showing compassion (Holly, Hannah); being empathetic (Holly, Lauren); sharing the emotion with the family (Holly); and one that is peaceful for the patient (Luke, Renee). Contributing to a good death is the honour of providing end of life and after death care (Grace) and the privilege of being present at the end of life (Holly). The overarching thread for 'good death' is the perception of death as 'beautiful'. This is the first published study that revealed the nursing students' perception of a death as beautiful, as a significant thread (Gillan et al., 2016) and the contribution that this study has made is noted in the work of Osterlind et al. (2016). Student perceptions of death as beautiful are significant because this shapes their expectations and aspirations for end of life care.

For those students who described death as beautiful or a privilege, their experiences were shaped by the social interactions of nurses or others present during the experience. For many students, it was the social aspects of care by the RNs that made the difference between a good (beautiful) experience or a bad experience. This is especially important for students when these are their first death experiences since these experiences travel with them into the future and have the ability to form and shape future experiences (Dewey, 1938). First experiences with death can be so profound and memorable that some students stated they will never forget their first experiences (Costello, 2006; Edo-Gual et al., 2014), made unforgettable because of the nurse supporting them at the time of the experience (Millie and Lauren). In Lauren and Millie's experience, there were many strategies these nurses used to help make this a good experience for them, for example, staying with the student and talking through and normalising the experience. David found the RN, who provided exceptional care, walked him through the experience and travelled alongside him on his learning journey. Millie, who has had vast experiences with end of life care, learned from others to 'go gently'. As a result, Millie now shows this sensitivity in her approach with other student nurses. For Claire, the nurse's protective behaviours made her feel supported and protected throughout her first death experience. Similarly, research conducted by Gerow et al. (2010) found that

nurses create a 'curtain of protection' to mitigate stress and grief and enable the provision of supportive nursing care (p. 124).

Role modelling exceptional care at the end of life has also been found to be a significant means of support for some students during clinical practice (Lauren, Renee, James, Holly, David, Ashley). For Lauren, her first good experiences with the RNs on clinical placement gave her the confidence for future end of life care experiences. Having the supportive influence of a nursing role model during death experiences (Anderson, Kent, & Owens, 2015; Benner, 2001, cited in Ronaldson, 2006; Perry, 2009a) and a mentor guiding students through end of life care experiences (Hagelin et al., 2016; Strang et al., 2014) are important supportive actions identified in the literature.

Clinical debriefing of end of life care experiences was also another supportive strategy experienced by some students. For example, following her first end of life care experience, Grace was given the opportunity to talk about the experience and debrief with the RN. Similarly, from the literature, regular formal clinical debriefing was found to have supportive effects on nursing students (Davies, 1995; Loos, Willetts, & Kempe, 2014). Keene, Hutton, Hall, and Rushton (2010) found bereavement debriefing focused on the emotional response of the healthcare professional and that afforded staff the opportunity to reflect on feelings and responses. Reflection, as a way of making sense of and learning from experience (Bulman, Lathlean, & Gobbi, 2012; Davies, 1995; Strang et al., 2014), and supervision and peer support were also found to be important supportive strategies in the clinical environment (Davies, 1995; Honkavuo & Lindstrom, 2014; Peterson et al., 2010a; Strang et al., 2014).

In contrast to embodied 'good death' experiences is the binary of disembodied 'bad death' experiences. From a nursing student perspective, 'bad deaths' are described as those where the person experienced pain, were unprepared, or lacked dignity (Adesina et al., 2014).

Luke's first bad death experience has travelled with him over the years and has left him angry about what could have been a better experience – it has become an experience of liminality for him. For Luke, this liminality has created spaces of reflection, the liminal spaces between inside and outside perspectives (Enosh & Ben-Ari, 2016). The liminal spaces of what was a difficult experience conflicting with what Luke subjectively imagines could have been a good death experience for his grandmother, have become, for Luke, an experience at the threshold (Kennedy, 2001, cited in Clandinin, 2013), a space of contradiction and tension (Heilbrun, 1999, cited in Saleh, Menon, & Clandinin, 2014). Within Luke's ontology of experience, he found himself "betwixt and between" (Turner, 1960, cited in MacArtney et al., 2017, p. 624), and in a state of "necessary in-betweenness" (Heilbrun, 1999, cited in Huber, Murphy, & Clandinin, 2003, p. 351), within the borderlands of living within the possibility of multiplicity of different experiences (Clandinin, 2013). The context of Luke's grandmother's death, within

the socio-political and institutional hospital context became an undignified death highlighting inequities of care. Luke's grandmother's death was socially constructed by the practices of the nurses providing end of life care. For Luke this was shaped into a bad death experience because the nurses attending to his grandmother lacked the skills and knowledge to implement palliative care to ensure a dignified death. Reflecting on Luke's bad death experience, I am hopeful that the simulation experience will help balance some of the inequities between good and bad death experiences and I am left wondering of the impact this may have on Luke's future end of life care experiences.

Similar to Luke's first death experiences, however, but in a different context, was Emily's first death experience as a young trainee AIN. Emily also found a lack of compassion and support throughout this first death experience. Luke's story with his grandmother's death and Emily's clinical experience highlighted the importance of end of life experiences with a nurse who takes the time and effort to show students the way, walks them through the steps, guides them through the experience (like Holly) and shows how nurses can make end of life challenging. This is also supported in the literature where students described end of life experiences as "awful" (Parry, 2011, p. 452), "unpleasant" (Strang et al., 2014), or even "frightening or terrifying" (Strang et al., 2014, p. 197). As can be seen from this research, RNs have the ability and power to shape end of life experiences into good death experiences, however, they also have the power to shape these into bad death experiences for students.

For some students, bad death experiences were personified as disembodied death experiences. For these students, disembodied experiences involved rituals surrounding after death care. The ritualistic 'wrapping in plastic' became a disembodied experience for both Sarah and Grace as their stories run alongside each other. Using different terminology, for Sarah, "wrapped in plastic" and for Grace, "bagged", gave a vivid image of how far removed these rituals of after death care were for these students. There is little evidence in the literature of such descriptions of post mortem care as "wrapping" the body (Parry, 2011, p. 450) and placing the body in a "special bag" (Edo-Gual et al., 2014, p. 3504) or "body bag" (Carman, 2014, p.136). This research adds great depth and richness of students' perceptions, feelings and experiences with these disembodied post mortem rituals.

The socio-cultural acts of post mortem care, in this instance, signified that the dead person's body was now a corpse, lacking markers that indicate life, stripped bare of clothes, jewellery and other personal or cultural objects. It was now an object altering the meanings attached to the person, reducing their subjectivity to that of object (Lawler, 1991, cited in Quested & Rudge, 2003). The final act of wrapping the body in a shroud and placing it in a plastic bag further defined the body as an object or a product of death (Scott, 2013; van der Riet, 1999a, 1999b). Nurses, by these very acts, mediated the shift from embodied personhood to disembodied corpse (Quested & Rudge, 2003). For Sarah and Grace, these acts of

disembodying personhood shaped the unreality of this experience and were juxtaposed with Holly's 'beautiful death' experiences.

For some students, disembodied experiences with end of life care involved the physical coldness of the dying or deceased person. For some students, the disembodied coldness of the patient was a shock (Poppy, Bree). This experience with the coldness of the body has also only been reported twice in the literature (Edo-Gual et al., 2014; Strang et al., 2014) and not to the depth provided in this research. This research adds depth and greater insight into the embodied experiences of students touching the deceased patient. This experiencing of coldness was not only limited to touching the patient but it also extended outward to the physical environment. The coldness of the room where after death care was undertaken shaped Sarah's disembodied experience. This description of the physical coldness of the environment is only seen elsewhere in the literature once (Ek et al., 2014), however, this literature does not include the depth described by Sarah.

These disembodied experiences for some students, were the result of a lack of preparedness to not only undertake the ritualistic after death care of placing the person in a shroud and then a plastic body bag, but also to expect the coldness of the deceased. This lack of preparedness surrounding after death care also reverberates throughout the literature. Beattie (2006) found that nurses typically received little or no after death care training, while Ronaldson (2006) suggested that students can fear and dread the first viewing of a deceased patient and that this can be allayed with guidance and mentorship. An important finding from my research suggests that RNs in clinical practice have a crucial role in providing this mentorship.

Whether death is described in terms of embodied 'good deaths' or disembodied 'bad deaths', what is evident in the literature is that death is ultimately a very complex, subjective, personal and is inherently a socio-political experience (Granda-Cameron & Houldin, 2012; Stevenson, Kenton & Maddrell, 2016). As nurses, we are called to remember. It is not possible to think about death without acknowledging the importance of remembering, whilst also experiencing encounters of forgetting. This can be seen through students' stories of remembering and in some stories of forgetting, as seen in James's story of forgetting his first death experience.

5.2.3 Embodied Knowing Reflected in Personal Items of Meaning (Spirituality; Beliefs About Death)

Embodied knowing, as proposed by Barbour (2004), is knowledge constructed, embodied, experienced and lived, woven together with passion, experience and individuality. Those students who brought items of meaning (n=9) to their interviews showed embodied knowing

of end of life and death and dying. These items have become an embodiment of themselves and their spirituality and have provided students with a conduit for spiritual healing (e.g. Luke). Although the literature acknowledges spirituality as a difficult concept to define (Ross, 2006), for the purposes of this research, spirituality is defined as: “A way of being and is often multiple in nature” (van der Riet, 1999b p. 25). Spirituality includes the person’s beliefs and values, involves a connectedness with others or nature (Ross, 2006) and emphasises the duality of body and mind (van der Riet, 1999b).

For some students who brought items of meaning, their spirituality was deeply embedded in their chosen items (n=3). For example, Renee’s spirituality was evident in her St Christopher’s signet ring, an enduring symbol of her own mortality and a conduit to her vast and varied experiences with death and dying. For Luke, the small pink ribbon served as a reminder and provided him a source of healing of his friend’s sister who committed suicide. Finally, Holly’s small butterfly decoration was a happy and comforting reminder of her grandfather. For some of these participants, their items of meaning provided a link to past experiences (Luke and Holly), with the item pulling them into the past experiences along a time continuum and pushing memories into the present (Sheridan & Chamberlain, 2011), providing a bridge across time. This research, the first of its kind on end of life care and end of life care simulation, adds great depth of understanding on undergraduate nursing students embodied knowing and spirituality.

5.3 Part 2: Transformative and Translational Landscapes of End of Life Care (Personal, Professional, Simulation)

5.3.1 The Sociality Commonplace of End of Life Care Simulation

Simulation is widely seen as a social experience in which students learn through social participation and interaction (Bland, Topping, & Tobbell, 2014; Elfrink, Nininger, Rohig, & Lee, 2009; Fey, Scrandis, Daniels, & Haut, 2014; Hober & Bonnel, 2014; Lavoie, Pepin, & Cossette, 2017; Leigh, 2008; Thidemann & Soderhamn, 2013). Simulated death for students in this study was also experienced as a social phenomenon, where learning and working with peers became a primary concept. Grace found talking through the experience with her peers helped to shape her experience and made her realise that she was not alone in the experience. Peer support through reassurance and direction (Bland & Tobbell, 2016), and peer learning (Berragan, 2011; Hober & Bonnel, 2014) eases students’ anxieties, builds confidence and clinical decision making skills (Owen & Ward-Smith, 2014).

For many students, their experiences in simulation were influenced by learning and working in small groups of three or four. Small group learning has been found to enhance learning,

provide the opportunity to learn from each other, share ideas and stories (Bland & Tobbell, 2016), gain hands on experience (Alinier, Hunt, Gordon, & Harwood, 2006) and allow active participation not experienced in large group simulations (Hooper, Shaw, & Zamzam, 2015).

The simulation experience also gave students the opportunities to experience simulation from a range of roles, giving them different learning experiences. Specific roles played in the simulations included the role of the RN (primary RN and secondary RN) for all five scenes, and the role of family members sitting by the patient's bedside during the dying phase. Playing the role of family members was a significant learning experience for many students and gave them the opportunity to experience this from the perspective of the family member. Luke found playing the role of the family member (grandson) enabled him to put himself in the emotional "headspace" of a family member (Gillan et al., 2016, p. 67) and gave him another perspective other than that of the nurse (Mackey et al., 2014). For some students (David and Emily), playing the family member brought back memories of their own personal experience that they were able to draw upon to inform the simulation experience and enabled them to play the role realistically.

The use of family in end of life care simulation is limited in the literature. In those studies that have utilised family in scenarios, various family members were played by faculty (Fink, Linnard-Palmer, Ganley, Catolico, & Phillips, 2014; Kopka, Aschenbrenner, & Reynolds, 2016; Kopp & Hanson, 2011; Kunkel et al., 2016; Ladd et al., 2013; Leighton & Dubas, 2009; Pullen et al., 2012; Twigg & Lynn, 2012); other health students (Sherlin & Quinn, 2016); senior nursing students (Owen & Ward-Smith, 2014; Sherlin & Quinn, 2016); paid actors (Bartlett, Thomas-Wright, & Pugh, 2014; Dame & Hoebeke, 2016; Eaton et al., 2012; Galbraith, Harder, Macomber, Roe, & Roethlisberger, 2014; Gannon et al., 2017; Tuxbury, Wall McCauley, & Lement, 2012); or other standardised patients, not specified (Ferguson & Cosby, 2017; Kear, 2013).

Studies that have included students participating in the simulation and playing the role of family members (Carman, 2014; Carman, Sloane, Molloy, Flint, & Phillips, 2016; Harder et al., 2013; Howard, Ross, Mitchell, & Nelson, 2010; Levett-Jones et al., 2015; Lippe & Becker, 2015; Sperlazza & Cangelosi, 2009; Swenty & Eggleston, 2011; Thidemann & Soderhamn, 2013) or of, to coin a new term, the 'standardised family', have not reported on the effects or potential benefits of immersion within scenarios as family members. This study, however, adds a greater depth of insight into the experiences of students and the benefits of incorporating family into scenarios, particularly with students playing the role of family members at the end of life, allowing students to experience the simulation beyond the role of the nurse or the observer (Gillan et al., 2016).

In support of family presence in simulation, this has been found to increase fidelity and enhance realism (Gillan et al., 2013, 2014b; Leighton & Dubas, 2009), improve communication (Fluharty et al., 2012) especially in difficult conversations surrounding end of life (such as Simon), and increase learning satisfaction and self-confidence (Swenty & Eggleston, 2011). Importantly, students understood the importance of being present with the patient and family (Fabro et al., 2014).

For all students, playing the role of the RN was a new experience for them. This became a valuable learning experience for students given they would soon become registered nurses on completion of their undergraduate program. This gave them the opportunity to step up to the role they would soon be living within their own professional lives across liminal spaces in imagining the multiple future possibilities. Although much of the end of life simulation research shows students playing the roles of nurses, there is only a small number that actually has students stepping up to the role of the RN in end of life care (Fabro et al., 2014; Fluharty et al., 2012; Twigg & Lynn, 2012). Moreover, these studies lack depth of detail on what this experience means for the student nurse taking on a more senior role, one that they will one day soon be living in their nursing careers.

5.3.2 The Temporal Commonplace of Simulation

5.3.2.1 Temporal continuity (moments in time surrounding death)

From this study, moments in time surrounding death were found to be significant. This concept of time continuum resonates with Dewey's (1938) criteria of experience of time continuum and Clandinin and Connelly's (2000) commonplace of temporality. Three significant moments in time along the time continuum and across a range of contexts (personal, clinical and simulated) became evident. They were, firstly, care before death; secondly, care at the time of death (being present and witnessing death); and thirdly, providing care after death. While most students experienced all three moments surrounding death, others had not experienced one or more of these moments which were to become, for them, forward looking stories reaching across the liminal spaces of time and imagining a future of possibilities (Clandinin, 2013).

The simulation gave some students their first unfamiliar experience of death. One student, Simon, had not experienced any of the moments of death in clinical or personal contexts. For Simon, the simulation gave him an important opportunity to experience death for the first time before he became an RN. Looking ahead, this gave him an experience he could draw on and relate back to during his first death in clinical practice.

While other students (Noah, Louise, Bree and Poppy) had cared for the person after death, they had not experienced the moment of death until the simulation and found the simulation's dying phase to be confronting or "scary" (Louise, Bree and Poppy). Several studies have suggested the importance of providing opportunities to be present at the time of death during clinical experiences (Edo-Gual et al., 2014; Ek et al., 2014; Huang et al., 2010; Kent, Anderson, & Owens, 2012; Strang et al., 2014; Zheng, Lee, & Bloomer, 2016). However, due to limited clinical placements (Sarabia-Cobo et al., 2016; Smith et al., 2018), there has been limited opportunity for students to experience the death of a patient during clinical placement.

Although there are several studies that cite scenes that followed the patient till the moment of death, most include either no information on the scenarios or death scene (Carman et al., 2016; Dame & Hoebeke, 2016; Ferguson & Cosby, 2017; Kopp, 2013; Lewis et al., 2016; Lippe & Becker, 2015; Moreland et al., 2012; Twigg & Lynn, 2012; Venkatasalu et al., 2015), or only include very limited information on the dying scene or the effects of this on student learning (Allen, 2018; Dame & Hoebeke, 2016; Fabro et al., 2014; Fluharty et al., 2012; Ladd et al., 2013; Lippe & Becker, 2015; Swenty & Eggleston, 2011). This research is the first of its kind to provide depth of information on end of life care simulation scenarios.

The number of scenarios used in the simulation is also of relevance to the simulation experience. In many studies, the stimulation was limited to only one scene (Allen, 2018; Carman et al., 2016; Dame & Hoebeke, 2016; Eaton et al., 2012; Ferguson & Cosby, 2017; Fluharty et al., 2012; Jeffers, 2018; Kunkel et al., 2016; Lewis et al., 2016; Lippe & Becker, 2015; Lindemulder, Gouwens, & Stefo, 2018; Moreland et al., 2012; Swenty & Eggleston, 2011; Twigg & Lynn, 2012). Other studies included two scenes (Bloomfield et al., 2015; Kopp, 2013; Sarabia-Cobo et al., 2016; Venkatasalu et al., 2015). Only two studies included more than two scenes (Gillan et al., 2016; Ladd et al., 2013). The limited number of scenes within the simulation limits the student's exposure of end of life care scenarios and does not provide a holistic or comprehensive end of life care simulation experience.

It is widely seen in the literature that many pre-registration nurses have not experienced care of the dying (or death) until after graduating and felt they needed this experience during their undergraduate degree (Anderson et al., 2015; Chow, Wong, Chan, & Chung, 2014; Croxon, Deravin, & Anderson, 2018; Grubb & Arthur, 2015; Kent et al., 2012; Zheng et al., 2016). End of life care simulation in my research gave some students their first insight into what caring for the person and their family up until and following death would be like for them in their future nursing practice. This first experience with death, prior to graduating as a new RN, has helped students to feel prepared for undertaking this care in the future.

5.3.2.2 Temporal discontinuity

Along the continuum of time, discontinuity related to time, a temporal discontinuity, was troublesome for two students. Firstly, playing scenarios in real time became a conundrum for one student (Ashley). For this student, shifting time forward (fast-forwarding the scene) would have allowed her the space to show she knew how to respond in each scenario. Although this was significant for this one student, this phenomenon of fast-forwarding is not described in the literature.

Secondly, the time limit of 10 minutes for the individual scenes was problematic for another student (Emily). Although students understood the rationale for time limits of the scenes, this brought some tension to those who felt restricted because of time constraints. Only a small number of studies mentioned pacing of scenarios as important (Abdo & Ravert, 2006; Lubbers & Rossman, 2017) and only one study included time limits (10 minutes) similar to this research (Bloomfield et al., 2015). However, these articles lack depth of information. This research uniquely provides greater depth and insight into the impact of simulation timing and sequencing.

Additionally, the timing of the simulation day may have affected students' experiences. In this research, I was restricted by the timing of the simulation days, conducted during a four day intensive residential school that fell after the clinical placement for the unit of study. This meant that students experienced the simulation after clinical placement experience instead of before clinical placement. Although not a specific finding from this research, this may have affected students' simulation experiences (Ladd et al., 2013). It has been suggested that in sequencing simulation and clinical placements, it is optimal that simulation occurs before clinical experiences (Woda, Hansen, Paquette, & Topp, 2017). This is especially important for end of life care simulation, potentially giving students the opportunity to experience and practise end of life care in simulated environments before clinical placement. However, the barrier for this sequencing was the nursing curriculum, which was often dictated by the clinical placement calendar. This study is the first to provide the depth on simulation sequencing on before or after clinical placement experiences and contributes significantly to limited available evidence.

Finally, the sequencing of unfolding simulation scenarios had become a conundrum for two students. For Emily and Ashley, the sequencing of unfolding scenarios out of order was perceived as problematic and caused some confusion possibly affecting clinical judgment. However, there is little evidence available on the impact of sequencing on student learning, with this research providing a depth of insight into this. Of those studies that have mentioned simulation sequencing of unfolding simulation scenarios (Mills et al., 2014; Rode, Callihan, & Barnes, 2016; Sperlazza & Cangelosi, 2009), they have not focused on end of life care simulation and have not provided any depth on the outcomes of this. Despite this limitation,

the unfolding scenario format allowed a longer more in-depth scenario to evolve building complexity in the scenarios (Sherlin & Quinn, 2016). This finding has been supported by this research.

5.3.2.3 Liminal spaces of looking to the future (Imagining new possibilities amidst the professional landscape of end of life care)

For a handful of students, the simulation gave them a sense of looking ahead to their future clinical practice as a registered nurse. These liminal spaces of looking ahead into the future allowed students to imagine themselves within different possibilities (Clandinin, 2013) as an RN.

For Simon, looking ahead across liminal spaces to one day in the future, he imagined that one day it could be him who was the primary person answering the difficult questions and dealing with end of life care in clinical practice. For Simon, this was a confronting thought since he had not previously experienced death in clinical practice and did not know how he would react when faced with this for the first time as an RN. Looking ahead and imagining future reactions was seen only once more in the literature on students' experiences with death and end of life care (Ek et al., 2014). However, Simon felt that following the end of life simulation he would be able to reflect back on this experience when he encountered death for the first time in clinical practice. This sense of looking ahead and remembering simulated death was only evident in the literature on end of life simulation on two occasions (Kopka et al., 2016; Strang et al., 2014). However, the depth of these experiences was limited with this research adding great insight and richness of detail on students' experiences.

5.3.3 The Commonplace of Simulation Landscapes of Death and Dying

5.3.3.1 Real versus unreal simulation landscapes

For some students, the simulation highlighted the binary of real versus unreal landscapes within the simulation. For those students who found the simulation unrealistic, it was either the simulation environment or the simulation manikins that made this an unreal landscape.

Two students (Poppy, Renee) commented on the unrealism of the manikins in the simulation, referring to these as "dolls" or "dummies". The issues with the use of manikins and fidelity is a well-documented limitation of simulation (Baxter, Akhtar-Danesh, Valaitis, Stanyon, & Sproul, 2009; Kameg, Clochesy, Mitchell, & Suresky, 2010; Oberleitner, Broussard, & Bourque, 2011; Power et al., 2016). Manikins by their very nature, made of rubber and not real, are the focal point of this unrealism. However, it is the use of props (e.g. vomit bowl with

emesis, syringe driver, medication charts etc.) and attention to detail that can add a dimension of realism to the simulation. In this instance, the addition of a patchwork quilt on the bed in the dying scenario also added a sense of personalising and embodying this experience for students. The inclusion of such personalised items as a patchwork quilt is only cited once in the available literature (Sherlin & Quinn, 2016). The importance of the physical simulation environment mimicking the intended environment as close as possible to reality enabled the students to immerse themselves in an experience that was close to real life (Seropian, Brown, Gavilanes, & Driggers, 2004).

Juxtaposing the unrealism of the manikins was the realism of the simulated patients. This was seen in the storylines of Hannah, Renee, Bree, Simon and Luke in comments on how realistic the actors were playing their roles. The use of standardised patients added the dimension of sociality to the simulation and increased the realism of the simulation experience (Elfrink et al., 2009; Fink et al., 2014; Mills et al., 2014; Owen & Ward-Smith, 2014; Seropian et al., 2004; Terzioglu et al., 2016). Furthermore, it increased the emotional engagement in the simulation (Bremner, Aduddell, Bennett, & VanGeest, 2006; Hjelmfors et al., 2016; Sperlazza & Cangelosi, 2009; Wyrstok, Hoffart, Kelly, & Ryba, 2014) and some students had even shed tears during the experience (Carman et al., 2016; Kirkpatrick et al., 2017; Kunkel et al., 2016).

Some studies found that end of life care simulation gave students the ability to confront their emotions, embrace end of life care, and transform perspectives on end of life from negative to more positive perspectives (Carmen et al., 2016; Kunkel et al, 2016).

The physical spaces of the clinical laboratories also added a dimension of unrealism for some students (Bree and Emily). The clinical laboratories were perceived as clinical teaching spaces where clinical skills were taught and practised, instead of simulation spaces and impacted on how they acted within these spaces. For Emily, the unrealism of the clinical laboratories was juxtaposed with the realism of the simulation laboratory. The simulation laboratory space was set up to look like a hospice room including flowers by the bedside and a homemade patchwork quilt on the bed. The realism of this space enabled her to feel safe and play the role of the family member more realistically. For Emily, this “psychological fidelity” (Pike & O’Donnell, 2010, p. 406) enabled her to associate the simulated setting with a real life clinical setting. The physical setting or situation is important in shaping experiences (Clandinin & Connelly, 2000; Dewey, 1938; Wang, 2017).

5.3.3.2 Simulation crossing borderlands of clinical and personal landscapes

For some students (Emily, David, Holly), there was also an intertwining of experiences across all three landscapes: clinical, simulated and personal as their experiences overlapped,

drawing upon previous experiences as they worked through the simulation scenes. For others, such as Renee, her previous experiences as a police officer dealing with traumatic death intertwined with her beautiful end of life experiences whilst on clinical placement, linking experiences across these two landscapes and across time. Kunkel et al. (2016) similarly reported that students in end of life care simulation overlapped with clinical and personal (family) experiences, while Chow et al. (2014), Garrino et al. (2017), Kear (2012) and Smith-Stoner (2009a) found that students' personal lives intertwined with their professional nursing lives.

5.3.3.3 Simulation debriefing landscapes – spaces for reflection

The simulation landscapes provided students with a safe environment to experience end of life care. However, it was the simulation debriefing landscapes that allowed for exploration, growth and depth of learning through reflection (Chorister & Brown, 2011; Dreifuerst, 2009; Dufrene & Young, 2014; Fey et al., 2014; Hober & Bonnel, 2014; Neill & Wotton, 2011). Furthermore, during debriefing, participants were encouraged to explore emotions (Allen, 2018) and question and reflect on the simulation experience with the purpose of moving toward assimilation and accommodation to transfer of learning to future similar situations (Meakim et al., 2013).

Simulation debriefing is considered an essential part of learning during simulation, so much so that many researchers have devoted entire journal articles to critiquing the use of debriefing in simulation; they are too vast to include all here, therefore, only the most recent are included (Abelsson & Bisholt, 2017; Al Sabei & Lasater, 2016; Bradley & Dreifuerst, 2016; Dias Coutinho, Martins, & Pereira, 2016; Dreifuerst, 2015; Fey & Jenkins, 2015; Johnston, Coyer, & Nash, 2017; Kim & Kim, 2017; Lavoie, Pepin, & Cossette, 2015; Lavoie et al., 2017; Palaganas, Fey, & Simon, 2016; Reiersen, Haukedal, Hedeman, & Bjork, 2017; Roh, Kelly, & Ha, 2016; Tosterud, Hall-Lord, Petzall, & Hedelin, 2014; Wazonis, 2014, 2015). However, the focus of this literature is on simulation in general. So far, none of the literature available on end of life care simulation addresses the importance of simulation debriefing to much depth with the exception of this research. The literature on end of life care simulation that includes some discourse on simulation debriefing does so primarily in passing, as a brief comment only (Bloomfield et al., 2015; Dame & Hoebeke, 2016; Eaton et al., 2012; Ferguson & Cosby, 2017; Gannon et al., 2017; Leavy, Vanderhoff, & Ravert, 2011; Leighton & Dubas, 2009; Leighton, 2009; Moreland et al., 2012; Malone et al., 2016; Pullen et al., 2012; Smith-Stoner, 2009a, 2009b; Sperlazza & Cangelosi, 2009; Twigg & Lynn, 2012). There are a small number of papers that include end of life care simulation debriefing as an important finding or thread in their research (Gillan et al., 2013, 2014b; Kirkpatrick et al., 2017; Sherlin & Quinn, 2016).

For students, the simulation debriefing provided them with the avenue for reflection on the simulation experience as well as other experiences and enabled the students to synergise and consolidate their learning from the simulation, linking theory to practice. This reflection is an essential component of the simulation experience and is acknowledged to help bridge the theory to practice gap (Scully, 2011).

During simulation debriefing students learned from others' perspectives and experiences. Sociality in the debriefing was evident with students looking relaxed, laughing, joking and communicating openly with simulation facilitators. This was in stark contrast to how some students felt judged by peers and educators in the clinical laboratory landscapes. The debriefing landscapes were spaces where they felt they could relax and unwind following the intensity of the simulation.

Regardless of whether the discourse on debriefing is focused on simulation in general, or specifically on end of life care simulation, the consensus is that debriefing following simulation is essential (Shinnick, Woo, Horwich, & Steadman, 2011) if not the most significant or important component of simulation (Bradley & Dreifuerst, 2016; Decker et al., 2013) and is crucial in the facilitation of learning (Cantrell, 2008; Johnston et al., 2017; Levett-Jones & Lapkin, 2014; Shinnick et al., 2011;). Debriefing is also an integral component of the teaching and learning strategy of simulation (Cantrell, 2008; Jeffries 2005; Lusk & Fater, 2013). Furthermore, debriefing allows students to consolidate and reflect upon their learning experiences and promotes knowledge transfer to new or similar situations in clinical practice settings (Nash & Harvey, 2017).

5.3.4 Theory, Practice and Experience Synergised

For many students, end of life care simulation became transformative and translational experiences providing a means of linking theory to practice. For these students, the end of life care simulation gave them transformative experiences that they could take with them into clinical practice and help prepare them for providing quality end of life care. Significant benefits included improved communication skills in approaching difficult conversations at the end of life; increased knowledge on issues surrounding end of life care; increased self confidence; self competence; improved attitudes; reduced anxiety; and increased comfort in providing end of life care to patients and, importantly, to family members.

Linking theory and practice, otherwise known as transfer of learning, is a widely accepted benefit of simulation in various forms and is a common theme across the simulation literature (Baptista et al., 2016; Berragan, 2014; Bradley & Dreifuerst, 2016; Bremner et al., 2006; Hope, Garside, & Prescott, 2011; Johnston et al., 2017; McCaughey & Traynor, 2010; Mills

et al., 2014; Neill & Wotton, 2011; Thidemann & Soderhamn, 2013). However, it is limited specifically to end of life care simulation (Gillan et al., 2013; Venkatasalu et al., 2015).

The concept of transformative learning has been well established in the literature. From foundational work by Mezirow (1978) on transformative learning theory, it is defined as:

A theory that describes the experience and cognitive process by which adults critically evaluate previously unexamined beliefs, values and assumptions; try new beliefs, values and assumptions to determine the fit for themselves; and then develop a dramatically new perspective of their worldview. (Mezirow, 1978, cited in King, 2007, p. 26).

Mezirow's (2000) 10 phase process of transformational learning involves two critical components of reflection: critical reflection and rational/reflective discourse (Merriam, 2004). Mezirow (1990, p. 7) refers to critical reflection as "challenging the validity of *presuppositions* in prior learning".

Critical reflection on experience is key to transformative learning, where effective learning arises from effective reflection (Merriam, 2004). It is through this critical reflection in simulation debriefing that this transformative learning occurs during simulation.

Another significant component of Mezirow's transformative learning theory includes a "disorientating dilemma" (Mezirow, 1998, p. 196). According to Mezirow (1995, cited in Parker & Myrick, 2010, p. 328), true learning occurs when individuals are faced with a "crisis or major transitional experience", a "disorientating dilemma" that challenges their thinking. During this research, students were confronted with the disorientating dilemmas of caring for the dying patient and approaching difficult conversations. In the simulation, this transitional experience for some students was when the patient asked if they were dying, while for others such as Simon, this transitional experience was the dying scene and witnessing the death of a patient for the first time. These disorientating dilemmas were emotionally charged for students, throwing them out of their comfort zone and disorientating them momentarily. However, during the simulation debriefing, through reflection and connection with the sociality of others experiencing the same disorientating dilemma and similar transformations, students discovered new ways of interpreting meaning from the experience (Parker & Myrick, 2010), transforming and consolidating their learning.

The essence of Mezirow's transformative learning is perspective transformation (Mezirow, 1978, 1990, 1994), the process of changing a person's frames of reference (or meaning structure) acquired through life experiences (Dirkx, 1998). This perspective transformation can be seen in how the students now approached the nursing care of their patients at the end of life in the use of touch (James), challenging doctors' medication orders (Millie), in

approaching difficult conversations (Luke), and in the liminal spaces of imagining how end of life care will be as an RN (Simon).

Several students found the simulation helped improve communication skills. For example, Luke in particular found that the simulation gave him the opportunity to improve his communication skills at the end of life, something he was then able to take with him into clinical practice. Similarly, Lauren, too, found the simulation helped improve her communication skills and this has given her the confidence to manage those difficult conversations at the end of life. For Emily, her learning took a different shape as she learnt through the simulation experience to 'get behind the question' thereby fine-tuning her communication skills. Simulation as a means of improving communication skills is widely seen in the literature on simulation (Bambini, Washburn, & Perkins, 2009; Kameg et al., 2010; Leigh, 2008; Malone et al., 2016; Pike & O'Donnell, 2010; Schoening, Sittner, & Todd, 2006) and on end of life care simulation (Bloomfield et al., 2015; Dame & Hoebeke, 2016; Efstathiou & Walker, 2014; Fabro et al., 2014; Ferguson & Cosby, 2017; Fink et al., 2014; Fluharty et al., 2012; Gannon et al., 2017; Gillan et al., 2014b; Hjelmfors et al., 2016; Kirkpatrick et al., 2017; Smith et al., 2018).

For many students, the simulation provided them with the opportunity to increase their knowledge on end of life care. The most significant gain in knowledge was on the use of medications at the end of life to manage symptoms such as pain (Holly, Renee and Millie) and provide comfort measures and address symptoms first (Noah). Taking a different shape in learning from the simulation experience, in the liminal space of his clinical practice experiences after the simulation, David reflected on a recent experience with a patient dying on the surgical ward. During this experience, he remembered the dying scene in the simulation which he felt prepared him for this clinical experience. This knowledge acquisition specific to end of life care simulation is also seen in some of the recent literature (Fabro et al., 2014; Fink et al., 2014; Fluharty et al., 2012; Gannon et al., 2017; Gillan et al., 2014b; Kirkpatrick et al., 2017; Leighton & Dubas, 2009; Moreland et al., 2012; Twigg & Lynn, 2012). Some studies also found that students felt the simulation was an effective learning strategy (Lindemulder et al., 2018; Lippe & Becker, 2015) for undergraduate students with or without previous nursing experience (Lippe & Becker, 2015).

For some students, their increased knowledge improved their self-confidence in their abilities to provide care at the end of life. Millie found that her improved medication knowledge gave her the confidence and empowered her to challenge a doctor in her clinical practice. This has had significant impact on her clinical practice as she now feels more confident to do this if required. Luke also found he had improved self-confidence which enabled him to tackle difficult conversations with patients on issues surrounding end of life, following his simulation experience. This increase in perceived self-confidence or self-efficacy is also supported in

the literature on end of life care simulation (Eaton et al., 2012; Fink et al., 2014; Fluharty et al., 2012; Hjelmfors et al., 2016; Ladd et al., 2013; Moreland et al., 2012; Swenty & Eggleston, 2011; Wyrostok et al., 2014).

Similar to self-confidence is that end of life care simulation was found to significantly increase students' perceived self-competence in caring for patients at the end of life (Betcher, 2010; Carman et al., 2016; Dame & Hoebeke, 2016; Fink et al., 2014; Fluharty et al., 2012; Kirkpatrick et al., 2017; Kunkel et al., 2016; Ladd et al., 2013; Leighton & Dubas, 2009; Lippe & Becker, 2015; Moreland et al., 2012; Swenty & Eggleston, 2011).

End of life care simulation has also been shown to improve attitudes towards caring for the dying person and their family (Carman et al., 2016; Dame & Hoebeke, 2016; Jeffers, 2018; Lewis et al., 2016; Lippe & Becker, 2015); reduce anxiety about providing care for the dying patient (Kunkel et al., 2016; Venkatasalu et al., 2015; Kunkel et al., 2016; Kirkpatrick et al., 2017); and improve comfort (Ferguson & Cosby, 2017; Hjelmfors et al., 2016; Ladd et al., 2013) in providing end of life care for dying patients and their families.

Finally, end of life care simulation has shown the potential to increase preparedness for care of dying patients and families in future clinical practice (Bloomfield et al., 2015; Ferguson & Cosby, 2017; Venkatasalu et al., 2015). Preparation for clinical practice and emotional preparedness were key themes from the qualitative phenomenological study by Venkatasalu et al. (2015).

End of life care simulation has been shown to be transformational in improving communication, knowledge, self-confidence, self-competence, attitudes, comfort and anxiety and are translational to clinical practice with the potential to improve experiences for patients, families and nursing students.

5.4 Strengths and Limitations of the Study

In this thesis, students' stories of end of life care and end of life care simulation have been presented. Whilst every effort has been made to ensure this study was rigorous, there have been some limitations to the simulation experience and in the research design.

Limitations in relation to the simulation experience focus on three temporal aspects of the simulation. In the first instance, the timing of simulation sessions during students' residential school: unfortunately these were held after students' clinical placement for the palliative care unit of study. Timing, out of sequence for clinical placement meant that this has limited the results of my study in understanding the true impact (Research aim 3) that end of life care simulation may have potentially had on students. Although this issue was beyond my control

as an academic and a researcher, clinical placements are the driving force behind curriculum structure and these dictate when teaching occurs within the curriculum. However, this issue of time then provides evidence and support in ensuring that end of life care simulation experiences are provided before clinical end of life care experiences, and may potentially have an influence on curricula design.

The second instance, and perhaps a limitation to be addressed for future design of end of life care simulation, is the sequencing of the unfolding simulation scenes. As shown in this research, it is optimal for students to experience unfolding scenes in sequence. In a fantasy world of unlimited resources and unlimited time perhaps this is possible. However, in the real world of teaching, this is one limitation that needs careful consideration and may not be as easily solved in simulation practice when using unfolding simulation scenarios.

Finally, students' previous experiences with death and dying along a continuum of time were revealed across the three different contexts. As Dewey (1938) professed, all previous experiences have an impact on present and future experiences. Coming into the simulation experience, many students relived past experiences that informed their simulation experience and intertwined across all three landscapes (personal, clinical and simulation). The impact of these experiences was not really appreciated by me, as the researcher, until these experiences unfolded during participant interviews and explored through analysis when it then became clear to me how important and how influential these past experiences were for students. This limitation, however, will impact on future simulation, where previous experiences of students can be explored in simulation pre-briefing and embraced during the simulation and debriefing experience. Results of this research, through dissemination, can also inform others who are tasked with end of life care simulation. However, this is not only limited to simulation on end of life care and needs to be a consideration for all simulation addressing other difficult issues and may be particularly useful in simulations related to failed resuscitation, or the deteriorating patient.

Limitations to the research design, firstly, lie in the number of research participants included in this research. In hindsight, limiting participants to a more manageable number of around six to eight participants for a qualitative research study using narrative inquiry would have been sensible and meant I could have provided more depth and continuing attention to the complexity of students' stories and experiences. However, as a novice researcher and excited about undertaking this research and the interest from students, I was motivated to obtain as much rich data as possible in my area of interest. As a consequence, field text and research texts became intertwined and tangled and were at times overwhelming to manage. A recommendation following this is to limit the number of study participants when using narrative inquiry methods as well as limit the number of data collection methods.

Secondly, the data collected from the dying scene video (Scenario 5) and the simulation debriefing did not add new findings but confirmed the findings derived from the interviews. It was found that the conversational nature and the one-to-one personal interviews provided great depth of richness of students' experiences that could not be replicated in the other forms of field texts.

Thirdly, research participants were asked to bring along an item of meaning to the interview that was meaningful to them of their experiences with end of life care, both personal and professional. However, only nine students brought along items of meaning and only three of them were related to the end of life or death and dying. Although I was hopeful all participants would bring items of meaning, I did feel a sense of tension that participants did not see this as a significant part of the research process. For those who did bring items that were not included in the final research texts, a great deal of thought and wondering went into considering the relevance of each item. Reflecting deeply on these wonderings, I decided not to include those considered not to have specific relevance to my research puzzle or address the research aims and that did not facilitate deep discussion on experiences. Although I felt this was an important part of my research, not using these, I feel, is justified and is supported by Clandinin and Caine (2013) who suggested, that sometimes, artefacts are not in themselves part of the research field texts.

Finally, this research was limited to only one small, rural university in NSW, Australia. Although limiting participant numbers was the motivation for this, regardless, the results of this research need to be considered in view of this limitation. Despite this potential limitation, the large number of study participants provided enough data to address my research puzzle comprehensively.

Despite some limitations, there were a number of strengths to this research. Firstly, this study adds to the limited amount of research, especially qualitative, on end of life care simulation. Although this is a growing area in simulation, as evidenced through the increasing numbers of publications on end of life care simulation, since I embarked on my research journey nine years ago, this research is ground breaking as the first narrative inquiry research on end of life care simulation that has provided a comprehensive insight into the experiences of students. Secondly, the strengths of narrative inquiry add a further dimension of strength to this research. Narrative inquiry is a holistic research methodology that encompasses a view of embodied human experience from the three commonplaces of sociality, temporality and spatiality. Finally, as a relational methodology, narrative inquiry places the participant at the centre of the research, where research texts are co-constructed in partnership with the researcher. As the researcher, I, too, am positioned at the centre of this research, sharing experiences that have shaped this simulation into humanistic experiences for participants. From my own narrative beginnings, across clinical end of life care experiences and finally, to

teaching end of life care simulation, my own stories of experience are intertwined with the participants stories in relational ways.

Specific insights not yet seen in previous literature include students' embodied good death experiences and disembodied bad death experiences. Firstly, this research has provided rich insights into students experiencing and defining death as beautiful. In juxtaposing death experiences, this research has revealed disembodied experiences with post mortem care and the depth of feelings regarding this ritualistic practice as well as students' perceptions of the physical coldness of the deceased. Secondly, insights into students personifying death experiences through embodied items of meaning reflecting their spirituality and meaning making in relation to death and dying give new perspectives on students' embodied experiences with death and dying.

Simulation insights gained include immersion of students in the role of family in the simulation; the patient dying in the simulation scene; timing of simulation scenarios; and simulation sequencing with clinical placements. The unfolding nature of simulation scenarios is also significant in providing students with a comprehensive and holistic end of life care experience and is a significant strength of this research.

Furthermore, this study included a wide range of participants, from a variety of backgrounds and importantly, has a significant number of male participants (five out of 18; or 27%) which has widened the scope of understanding students' experiences with end of life care and end of life care simulation.

Additionally, this research provides support in the use of end of life care simulation as a pedagogical, learning centred, active learning strategy to teach end of life care, improving experiences for students, patients and families alike. Thirdly, this research has demonstrated benefit for improving student communication with difficult conversations, improving student self-confidence, and in preparation for providing end of life care to patients and families in clinical practice.

Finally, this research has the potential to impact on future education practices and education policy to inform curriculum development, and will contribute to the development of a teaching guideline for using simulation for end of life care. This guideline will underpin further evaluation of simulation in nursing education, practice and research.

5.5 Implications and Recommendations for End of Life Care Education, Simulation and Clinical Practice Landscapes

From this research, several implications for practice have arisen from which recommendations for end of life care education, end of life care simulation, and clinical practice on end of life care can be drawn.

Firstly, students need to be provided with effective preparation for end of life care experiences on clinical placements. This is especially important to those students who have not yet experienced death. Furthermore, education on end of life care needs to be commenced early in the undergraduate degree, during students first year before first clinical placement. This is important because experiencing death is a significant concern for first year nursing students going on first clinical placement (Poultney, Berridge, & Malkin, 2014; Edo-Gual et al., 2014). Nursing clinicians play an important role in supporting student nurses through their first death experiences. Providing clinical supervision and time for reflection (Osterlind et al., 2016) and the opportunity to talk through the death experience are mandatory to ensure positive experiences for students. Preparation should also extend to support and education in knowing when to be silent and the appropriateness of holding the person's hand (Osterlind et al., 2016) or the use of touch at the end of life. The role modelling use of touch in simulation has been shown to have significant benefits for the therapeutic use of touch in clinical practice and is a recommendation from this research.

Furthermore, students need to be prepared for the possibility of 'bad deaths' occurring in clinical practice so there are no ugly surprises. Arising from this research, it is recommended that simulation scenarios include a range of possible bad death scenarios including, for example, respiratory distress, terminal restlessness/agitation and palliative care emergencies such as haemorrhage, and seizures. Additionally, it is important that simulation scenarios include post mortem care (including labelling and placing the deceased in the plastic bag) in preparation for clinical practice (Edo-Gual et al., 2014). This is significant since preparation and support of the patient and family "precedes and surpasses death itself" (Salum et al., 2017, p. 532).

Nursing educators need to prepare students for the possibility that previous experiences and memories, good or bad, may arise during simulation and that these are valuable learning experiences that need to be addressed and worked through during pre-briefing and or debriefing simulation sessions.

Finally, the limited availability of clinical experiences with death and dying is a growing concern for undergraduate nursing students. This highlights the need for the provision of well thought out simulated end of life care experiences covering a range of end of life care issues.

Arising from this research are several recommendations specific to end of life care simulation. Firstly, small group sizes of three or four participants have been shown to be an important means of providing quality end of life care simulation experiences and are recommended in simulation practice. However, several barriers to this need to be considered for this can be adopted when dealing with large numbers of nursing students.

Secondly, the role students play in simulation has significant implications for their learning experiences. Immersing students within the roles of family members in simulation has given them an opportunity to experience end of life from a perspective other than a professional nurse, giving them a significant learning experience and is a recommendation for simulation practice arising from this research. Being in someone else's shoes promotes caring, compassion and empathy in providing end of life care which will have lasting clinical effects on patients and family's experiencing death.

Additionally, playing the role of the RN provided additional depth of meaning for students as they took on the role and responsibility and rose to the challenge of managing difficult conversations at the end of life. Students need to be given the opportunity to gain experiences in simulation as RNs to help prepare them for future experiences with end of life care and empower them to take on responsibilities in clinical practice.

What is evident from my research is that a discourse on death and dying was difficult for nursing students. Therefore, education in how to have difficult conversations with patients and families in simulation scenarios is an important means of preparing students for end of life care. Zimmermann and Rodin (2004) called for better education in managing difficult discussions about death and dying, to ensure support is provided for dealing with the emotional impact of these conversations.

Temporal issues within simulation have been found to have implications for end of life simulation teaching. Firstly, including the three moments in time along the end of life care continuum (before death, at the time of death and after death) in simulation has provided students with a comprehensive and holistic simulation experience and has given some students their first experience with witnessing the moment of death of a patient.

The sequencing of simulation scenarios unfolding in order of sequence has been noted as important to some students. Although everything possible is done to ensure that sequencing of scenarios unfold in correct chronological order along a normal time continuum, at times some students will be required to go out of sequence in unfolding scenarios. The only way to avoid this occurrence is to include stand alone cases instead of an unfolding simulation. However, this does limit the ability of the student to follow a patient through a sequential series of symptoms through different scenes that build complexity within the patient scenario. Additionally, most of the available research on end of life care simulation is limited to only

one or two scenes, regardless of whether these are unfolding or stand alone cases. The limited number of scenarios in simulation only provides students with a snapshot of end of life care simulation and limits the depth and continuity of the experience. In designing such simulations, academic staff must weigh up the benefits versus limitations of choosing unfolding scenarios or building complexity into stand alone cases. Simulation that includes a variety of scenes and a variety of roles which involve the moment of death and beyond, is recommended to provide a holistic end of life care experience.

Finally, a finding from this research suggests that sequencing of the simulation experience before clinical placement is preferable. Research on simulation in general (Reierson et al., 2017; Woda et al., 2017) and end of life care simulation (Ladd et al., 2013; Smith et al., 2018) supports this finding.

Simulation realism has been shown to have an impact on learning. Of all the scenes, the students felt that realism was affected by the presence of the manikin (unconscious scene and dying scene). In this instance, the simulation realism was enhanced by the actor playing the specific role. Actors who played the role realistically, with strong emotion were found to be key to learning in this group of participants. Therefore, a recommendation from this research is that educators must provide sufficient support and preparation for simulated patients to ensure simulation realism is supported. Additionally, attention must be paid to the simulation environment to ensure psychological fidelity and student engagement.

Another important consideration for end of life care simulation is providing a range of simulation landscapes and attending to clinical simulation spaces to promote simulation realism. As can be seen from this research experience, alternative settings such as the community palliative care setting have provided valuable end of life experiences (evident in Renee's story). Including community palliative care within the simulation experience will provide students with greater understanding and appreciation for the importance of continuity of care across different contexts for end of life care.

Finally, simulation pre-briefing and debriefing are vital aspects of end of life care simulation. Simulation pre-briefing is a necessary component of simulation in preparing students for the death of the patient and is mandatory in promoting psychological safety of students in end of life care simulation (Gillan et al., 2014b; Kirkpatrick et al., 2017; Sperlazza & Cangelosi, 2009). Simulation debriefing is essential in helping students connect with their inner feelings on death and dying through reflection and has been shown to be instrumental in students' transformative learning. Therefore, sufficient time in simulation debriefing is required to promote quality reflection on sensitive end of life care topics.

The taboo and objectified nature of death has implications for end of life care for students. Normalising death is an important component of end of life care education and aligns with

the philosophy of palliative care that states palliative care “affirms life and regards dying as a normal process” (WHO, 2018, para 1). As shown in this research and in the literature (Edo-Gual et al., 2014), allowing the space and time for students to talk about and share their experiences help to normalise death and provide spaces of reflection on feelings and emotional reactions.

5.6 Directions for Future Research

As noted in Chapter Two of this thesis, there is still a paucity of published research on end of life care simulation. A review of the current literature has revealed only 20 research articles on end of life care simulation. The majority of these are quantitative (n=9) or mixed method (n=7) studies with a minimal number of qualitative studies (n=4). Alongside this, are a number of methodological issues evident in the available research.

Firstly, small sample sizes in quantitative and mixed methods studies limit the findings of these studies. Sample sizes in the available research literature ranged from n=14 (Moreland et al., 2012) to n=202 (Sarabia-Cobo et al., 2016). Of note is Fluharty et al.’s (2012) multi-site study including 370 senior nursing students. The limited number of research participants in quantitative and mixed method studies reduces the statistical significance and impact of these results, therefore, results of these studies need to be considered with caution.

Secondly, not all quantitative or mixed method studies included a pre-test/post-test design for comparison of results (Ferguson & Cosby, 2017; Kopp, 2013; Kunkel et al., 2016; Sarabia-Cobo et al., 2016), and only one study used a control group to compare teaching strategies and other interventions (Kopp, 2013). Additionally, while the majority of quantitative and mixed method studies used instruments with established validity and reliability, such as the FATCOD (Carman et al., 2016; Dame & Hoebeke, 2016; Ferguson & Cosby, 2017; Jeffers, 2018; Lewis et al., 2016; Lippe & Becker, 2015), two studies used instruments not yet evaluated for validity and reliability (Kopp, 2013; Sarabia-Cobo et al., 2016). Although many studies used reliable instruments, results are limited due to the self-reporting nature of instruments.

Finally, there are minimal qualitative studies on end of life care simulation (n=4). The methodologies used in these qualitative studies are: phenomenology (n=2); focus groups (n=1); and narrative inquiry (n=1). Therefore, this supports the need for increased qualitative research on end of life care simulation to truly understand the experiences of undergraduate nursing students with end of life care simulation.

Additionally, this research has uncovered a number of specific areas for potential research on end of life care simulation. Firstly, there is as yet no specific research on pre-briefing of

end of life care simulation. This is significant because of the nature of end of life care simulation, and students need to be prepared and pre-briefed for the eventuality of death as the simulation unfolds. Research on the best practices of simulation pre-briefing ensuring psychological safety of students is, therefore, a priority.

Secondly, research specifically on debriefing in end of life care simulation is absent. Although a number of journal articles citing specific research on debriefing in simulation are available, there are as yet none dedicated specifically to debriefing in end of life care simulation. Once again, this is a significant area of research that needs attention. Qualitative research in particular on understanding students' experiences is also called for.

Thirdly, a study comparing the different simulation models of unfolding case scenarios with individual stand alone cases in simulation is called for. Since this research used unfolding case studies, it is important to explore the value of this in comparison to other models used in end of life care simulation. This is to provide evidence based and best practice pedagogical approaches to teaching end of life care simulation.

Finally, undertaking this research amidst different contexts including universities other than the one where this research was conducted is recommended. Additionally, a larger sample size and mixed method studies to evaluate the benefits and limitations of end of life care simulation are recommended.

5.7 Reflections on my PhD Journey

Along my long research journey, ironically, it seems that death has been a constant (and unwelcomed!) companion. I started this journey as a death and grieving novice, having had only distant relatives who have died throughout my life's journey. Although I had many end of life care experiences as a nurse throughout my nursing journey and have found these to shape me into the committed and passionate registered nurse and nursing lecturer I am today, it wasn't until the last three years of my PhD journey that I really, socially and personally, experienced death. Death became a visitor, walking through my door unexpectedly and uninvited, and as yet has not completely departed from my life; despite intermittent absences, death soon returned with a vengeance. As I sit here writing this, the final part of my thesis, on this the cusp of the anniversary of my 16-year-old nephew's sudden and devastating death at the hands of a 21-year-old's drug induced psychosis, a new wave of grief overcomes me. Despite this, I have found strength among my family, supervisors and peers to push past these crippling moments of grief, believing that this pain can add richness to my experiences, reinforcing my relational ontological commitments that began with my

narrative beginnings as a novice nurse experiencing death for the first time during my nursing career.

As other deaths I have experienced during my PhD journey circle around me, firstly my selfless father, a hero in my eyes and others, dying from dementia alone in the solitude of his own confusion-addled brain, followed shortly afterwards by my death mother's death only a short few months later, a beautiful death contrasting sharply with others I have experienced. This death was closely followed by the death of a very close friend and colleague, taken prematurely by breast cancer, leaving behind young children of 18 months and three years of age. Lastly, the death of a best friend, another taken too soon by cancer.

The irony of this is not lost on me as at times, I have struggled to embrace my research topic. Yet, I draw deeply on my own personal, clinical and academic experiences with end of life care. My rich experience as a palliative care nurse has given me the appreciation for being witness to and sharing in these privileged moments in time. Reliving students' experiences and sharing in these with them during this research journey have also helped me cope with my own very emotional and personal end of life experiences. Students' experiences often at times resonated and intertwined with my own clinical experiences and very treasured personal experiences. Holly's experience of being there at the moment of her grandfather's death, watching him take his last breath, resonates with my own experience of sitting by my mother's bedside as she slowly and peacefully slipped away into the realms of death. Also, Renee's beautiful experience with community palliative care intersects and intertwines with my own experiences as a palliative care nurse, and reminds me of my passion for end of life care and my motivation to instigate end of life care simulation into the nursing curriculum with the aim of making a difference to the end of life experiences for patients, families and nurses.

5.8 Conclusion

As we journey through life, we are often confronted with significant life events that have the potential to travel alongside us as we continue our journey. One of the most profound and significant life events is death. Each and every one of us will at some time in our lives be faced with or confronted by death, in its many shapes and forms. Nurses in particular are uniquely situated on the front line of caring for people at the end of life and will frequently be charged with providing end of life care. Therefore, preparation is required to ensure sensitive and quality end of life care for patients and families. It was for this reason that I embarked on my research journey of exploring the experiences of student nurses with end of life care and end of life care simulation. My own first experiences left me feeling insecure and uncertain, faced with the confronting nature of death and dying (personal justification) (Clandinin, 2013). Emerging from my experiences I was empowered to find a way of improving end of life

experiences for other undergraduate nursing students (social justification) (Clandinin, 2013). Most significantly, I realised that by improving end of life care experiences for nursing students, our registered nurses of the future, the experiences of patients and families would also be improved (practical justification and shifting and changing practice) (Clandinin, 2013). It was not, however, until I became a nursing educator that I found the avenue to be able to fulfil this ambition.

During my research I had the privilege to work alongside and, in the midst, of a wonderful group of inspiring young (and older) student nurses who were at the time RNs of the future, but today are experienced and passionate RNs in their own right. Using a narrative inquiry approach, we co-constructed stories of end of life care and end of life care simulation that revealed commonalities and singularities of experience. Stories reveal threads of experience, often complex and difficult to disentangle (Clandinin & Connelly, 2000). Using the metaphor of a patchwork quilt, these entanglements of threads have been untangled and woven together much like a quilt is pieced together.

The overarching threads of: the role of others in shaping death experiences; attending to family at the end of life; managing self, amidst negotiating difficult conversations at the end of life; managing self, amidst unfamiliar landscapes of death and dying; theory, practice and experience becoming synergised; defining moments in time; real versus unreal landscapes in simulation; and finding comfort amidst learning and working together were found to resonate throughout and across participants and are important considerations for end of life care and end of life care simulation.

Moving from field texts to these final research texts was challenging. I found myself drowning in data, all of which seemed significant, however, a focus on the three dimensional narrative inquiry framework of sociality, spatiality and temporality has helped me keep centred on my research puzzle.

When I embarked on my research journey there was only limited literature on end of life care simulation. As my journey unfolded and I began publishing my work, a flurry of research followed. My own research has inspired a wider range of research literature on end of life care simulation, many citing my work. My own research continues to build on this expanding knowledge of end of life care simulation. More significantly, my research provides a great depth of understanding on this topic and has uncovered a rich variety of experiences, explored through narrative inquiry and grounded in the philosophies of Dewey (1938) and Clandinin and Connelly (2000).

As I travel to the end of my doctoral journey, I have come to appreciate the enormity of students' first experiences with end of life care, and I am now even more inspired to refine simulation experiences for students and improve clinical end of life care for patients and

families. Continuing my journey as an academic, I am excited about what future directions I can take with end of life care education and simulation, and the possibilities of future research into end of life care simulation.

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Appendices

7.1 Appendix A: Gillan, van der Riet, & Jeong, 2014a

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Review

End of life care education, past and present: A review of the literature



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Undergraduate nursing students

SUMMARY

Background: Research on end of life care education suggests that undergraduate nursing students are largely unprepared to provide end of life care to dying patients and their families. Although there have been attempts to address the issue of lack of preparedness, little is known on how to improve this.

Literature Review Aims: To examine how end of life care education has been delivered to undergraduate nursing students and to critically discuss the research on modes of delivery and teaching strategies.

Review Methods: An extensive literature search on end of life care education in the undergraduate nursing curriculum was conducted in CINAHL, Mosby's Index, Cochrane Database, Scopus, Eric via Proquest, and Medline. 18 research papers published between 1984 and 2012 that met the selection criteria are included in the review.

Findings: Findings of these 18 articles are reported under two main themes: Modes of End of Life Education Delivery and End of Life Care Education Initiatives.

Conclusion: This review highlights issues with end of life care education and suggests that end of life care simulation is an innovative strategy that may help to prepare undergraduate nursing students to provide quality end of life care.

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Introduction

Research suggests that nursing students have anxieties about and difficulty dealing with death and dying (Mallory, 2003). Students are not ready to cope with issues related to death and dying, feel unprepared to care for these patients (Johnson et al., 2009) and view caring for dying people and their families as one of the most distressing and potentially unpleasant tasks that a nurse can do (Allchin, 2006). Caring for dying patients also ranks highly on nurses' experience of stress (Gibbons et al., 2010) and is reported as the second most common source of nursing stress for Australian nurses (Johnson et al., 2009). These findings indicate that undergraduate nursing programs are not adequately preparing nursing students to care for people at the end of life (Mallory, 2003; Allchin, 2006; Johnson et al., 2009; Gillan et al., 2012). This lack of education is reflected in the level and quality of end of life care provided to patients (Mallory, 2003).

Background

Evidence suggests that end of life care education is an important factor in preparing nursing students for end of life care, and that this may be the most significant factor affecting nursing students' attitudes toward care of the dying (Frommelt, 1991). It is recommended that student's undergraduate training should include a significant amount of both didactic and clinical end of life content (Barrere et al., 2008; Mallory, 2003).

Despite of an increasing amount of death education in undergraduate nursing programs seen today (Barrere et al., 2008), there are many issues identified in the literature with end of life care education resulting in nursing students reporting feelings of lack of preparedness (Mallory, 2003; Dickinson et al., 2008; Johnson et al., 2009; Ramjan et al., 2010).

Research has revealed that there is little content on end of life care in undergraduate nursing textbooks. For example, Ferrell et al. (1999a); Ferrell et al. (1999b), Ferrell et al. (2000a); and Ferrell et al. (2000b) conducted an analysis of 50 nursing textbooks. These studies revealed minimal content on issues related to end of life care with only 2% of texts addressing an end of life topic (Ferrell et al., 2000a).

Furthermore, another major issue identified in the literature is lack of content on end of life care in the undergraduate nursing curricula. Education of death and dying continues to have a minimal

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and inconsistent presence in most undergraduate nursing curricula and training is neither adequate nor appropriate (Mooney, 2005; Barrere et al., 2008; Johnson et al., 2009). Despite attempts to adequately prepare students for end of life care many nursing programs do not have a dedicated or elective course on palliative or end of life care (Hurtig and Stewin, 1990; Barrere et al., 2008), instead integrating content throughout other courses in nursing (Hurtig and Stewin, 1990). In the United States of America, only 3% of 311 nursing programs surveyed had dedicated courses on end of life content in their curricula (Wells et al., 2003) and an average of less than 14 h was spent on end of life issues (Dickinson et al., 2008). In the United Kingdom a mean of between 7.8 and 12.2 h was spent on teaching about death and dying (Lloyd-Williams and Field, 2002). In Australia, of the 26 undergraduate nursing programs surveyed, only 8% (n = 2) allocated > 20 h, while 48% (n = 12) allocated 5–10 h of content on death and dying (Johnson et al., 2009). The authors recommended that urgent attention be given to embedding theoretical content in sufficient depth combined with teaching strategies to promote critical reflection in end of life care.

The literature highlights that not only is the amount of time dedicated to the content an important factor but also that the modes of delivery and teaching strategies used are also of importance.

Aims

The aims of the literature review were to 1) examine how end of life care education has been delivered to undergraduate nursing students over the last 30 years, and 2) critically discuss the research on modes of delivery and teaching strategies used in end of life care education in undergraduate nursing education.

This paper presents the findings of the first of a two part series exploring end of life care education in undergraduate nursing programs. Past and present methods of providing end of life care education in the undergraduate nursing curriculum will be discussed providing a uniquely Australian, as well as an international perspective. Part two will introduce the emergence of end of life care simulation and provide an extensive review of current evidence on end of life care simulation.

Review Methods

A search of published literature between 1984 and 2012 on end of life care education was conducted on Cumulated Index to Nursing Allied Health Literature (CINAHL), Mosby's Index, Cochrane Database, Scopus, Eric via Proquest, and Medline. The search terms used are cited in Table 1.

The preliminary literature search located 205 articles. These articles were reviewed for content specifically related to the inclusion criteria of: 'end of life care education'; and 'undergraduate nursing students'. A total of 61 articles met the inclusion criteria. A further 2 articles were identified from reference lists of the identified papers (n = 63).

Due to the high numbers of identified literature on this topic, the following criteria were used to cull high quality research studies: research that 1) specifically assesses modes of delivery and learning strategies on end of life education for undergraduate nursing students; 2) have a clear research question or research aim; and 4) have an identifiable study design. 18 research studies are included in the review. Table 2 provides a decision flow diagram.

Research papers were analysed using thematic analysis by the primary author. Two key themes were identified; Modes of end of life education delivery, including the subthemes of active and experiential learning; and education initiatives. Identified themes and subthemes were confirmed by the other authors of the review. This process of peer review ensured rigour and trustworthiness of thematic analysis.

Findings and Discussion

Modes of End of Life Education Delivery

End of life education in undergraduate nursing curricula has traditionally been delivered via theoretical methods in the form of classroom lectures (Hurtig and Stewin, 1990) and small group discussion (Johansson and Lally, 1991; Jo et al., 2009) and these continue to be the primary modes of teaching. However, traditional lectures and other didactic modes of delivery do not provide the opportunity for students to examine their personal reactions to their own experiences and to dying patients (Mok et al., 2002). More promising are the various modes of end of life care education that have recently emerged to promote active and experiential learning. These include hospice visits (Kwekkeboom et al., 2005, 2006), intensive death and dying education programs, and the use of audio-visual aids (Caty and Tamlyn, 1984; Hurtig and Stewin, 1990; Johansson and Lally, 1991; Jo et al., 2009; Dobbins, 2011). Table 3 depicts a summary of research studies on modes of delivery.

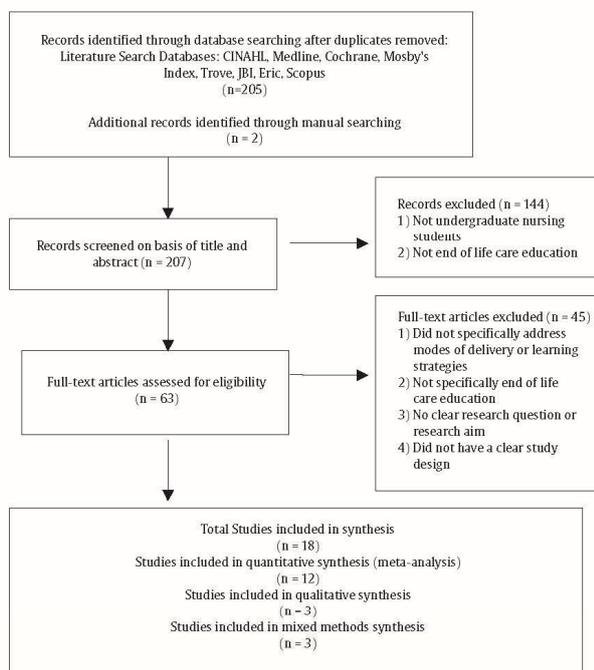
Active learning is a process that involves strategies or instructional methods that require active student engagement that promotes a greater depth of learning (Sand-Jecklin, 2007). The strategies and instructional methods used to promote students' engagement in thinking about their roles in end of life care include 1) listening to audio recordings (Johansson and Lally, 1991); 2) viewing selected films on death and dying (Caty and Tamlyn, 1984; Johansson and Lally, 1991; Dobbins, 2011); 3) use of art (Jo et al., 2009); and 4) discussions, quizzes and tasks (Lockhard, 1989; Jo et al., 2009). While it is acknowledged that these quantitative studies using experimental or quasi-experimental study designs made an innovative attempt at promoting active learning there are a number of issues identified in designing and implementing teaching strategies and methods.

Firstly, the instructional method should be purposefully selected and readily available. In the use of film, Dobbins (2011) recommends that film clips should be chosen to evoke desired emotions such as empathy and compassion. Secondly, the instructional method is most effective if accompanied by supplementary strategies such as group discussion and reflection. For example, Dobbins (2011) found the use of film to be more effective when followed by reflective learning activities. Thirdly, it is not only the quality of teaching method implemented but also other variable factors, such as the level of the student (junior level or senior level) to be considered for the teaching strategy to be effective. The death education program implemented by Johansson and Lally (1991), using audio and video clips was effective in decreasing the death anxiety of some senior students but increased the death anxiety of some of the junior students. Finally, Jo et al. (2009) incorporated multiple active learning strategies delivered over a 16 week death education program. They found that end of life care education positively affected students' care performance.

Table 1
Search terms used in initial search strategy.

Search Terms:	"AND"	Search Term limiters
Undergraduate Students/Nursing Degree	Nursing Degree	End of life care/Palliative care/Terminal care/Hospice care//
Students/Bachelor Degree	Bereavement/	-not end of life care
Nursing Students/ Baccalaureate Degree	/death/death and stress/Death education/curricula/ curriculum/undergraduate nursing programs	-not undergraduate nursing students
Nursing Students		-not education -conference abstracts -letters -editorials
Total results	61	Limiters: 144

Table 2
PRISMA flow diagram.



Active learning strategies were effective in clarifying the significance of the suffering experience positively affecting nurses' attitudes towards death. Although, this study involved a largely homogenous and small sample, the findings are important in adding to the limited available literature on such programs.

In summary, active learning processes provide an atmosphere that fosters discussion and acquisition of knowledge (Jo et al., 2009). However, for it to be effective, the issues discussed above need to be considered.

Experiential learning is described as learning that encourages students to reflect on and learn from human experience (Kwekkeboom et al., 2006). The strategies and instructional methods used to promote meaningful reflection and experience include 1) clinical case studies (Wong et al., 2001; Mok et al., 2002); 2) volunteer hospice companion programs (Kwekkeboom et al., 2005, 2006); and 3) palliative care educational component/death education program (Mallory, 2003; Hurtig and Stewin, 1990; Liu et al., 2011; Mooney, 2005). These studies demonstrate several innovative methods that promote experiential learning, however, there are some issues identified in the design and implementation of these teaching strategies and methods.

Problem Based Learning (PBL) focuses on students being confronted with "problems" to stimulate learning and discussion. Wong et al. (2001) and Mok et al. (2002) used PBL as an experiential learning strategy to enhance the attitudes, knowledge and skills of nurses caring for dying patients. It is notable that these are qualitative studies on modes of delivery of end of life care education while the majority of the studies are quantitative. In these studies, senior students' journals

were analysed using a case analysis approach. Students perceived that they acquired knowledge and communication skills through PBL. However, there were no systematic observations and evaluation of the students' communication skills in the studies to support the self-report of knowledge and skill acquisition. Although Wong et al. (2001) claimed that the use of PBL was an effective experiential learning strategy that encouraged critical thinking, creativity in learning, personal growth, team work, and research skills, due to study limitations these results require careful consideration.

Volunteer palliative care companion programs designed to provide undergraduate nursing students with experiential learning experiences are an innovative teaching and learning strategy for palliative care education. Two such programs by Kwekkeboom et al. (2005) and Kwekkeboom et al. (2006) demonstrate some promising results. Both studies used small sample sizes of 2nd and 3rd year undergraduate nursing students (34 participants and 52 participants respectively) and employed a quasi-experimental controlled pre-test and post-test study design employing three data collection instruments. Results indicated that students' knowledge of and attitudes toward palliative care improved and their concerns about caring for dying patients significantly decreased. However, the small sample size suggests the improvement was not statistically significant. Despite the small sample size this teaching strategy has the ability to provide students with experiential learning experiences with end of life care. Further rigorous evaluation beyond course evaluation needs to be undertaken to investigate if the improvement will be clinically significant before this strategy can be considered as an effective teaching and learning strategy.

Table 3
Summary of research studies.

Author/s/ year/country	Research question	Sample	Educational intervention	Research design/methods	Key findings
Johansson and Lally (1991) USA Active Learning Strategy	1) Would a death education program decrease death anxiety experienced by nursing students? 2) Does the level of the nursing student influence the effectiveness of the death education program in reducing death anxiety?	54 nursing students (22 junior, 32 senior, all female, average age 20.5 years).	1) Film "Crump: A man Ages and Dies"/ discussion 2) Audio "Facing Death with the Patient: An On-Going Contract" discussion 3) + 4) audio interview (Hospice Director)/ discussion; 5) Film "Death"/discussion 6) Audio—"Conversations with a Dying friend"/ discussion.	Quantitative: Randomised experimental group-control group, pretest-posttest design. Instruments: -State Form of the State-Trait Anxiety Inventory (STAI)	Findings: the death education program was effective in decreasing the death anxiety for some seniors, but death anxiety increased for some juniors. -Prior clinical experiences with dying patients may be the most important part of a relevant death education program. Limitations: small sample size; all female sample, ethical approval not discussed.
Jo et al. (2009) Korea Active Learning Strategy	No research question. Purpose of research: to examine the effects of end of life care education (using nurses' experience with suffering, attitude toward death, and end of life care performance as measurements).	47 senior nursing students (experimental n = 23; control n = 24), convenience sample enrolled in "Terminal end of life care course".	16 week End of Life Care Education Program: lectures with movies, discussions, quizzes, tasks, attitude toward death through works of art, etc.	Quantitative: Quasi-experimental, non-equivalent control group pre-post non-synchronised design. Instruments: -General characteristics -Suffering Experience of the Nurse -Collett-Lester Fear of Death Scale -End of Life Care Performance	Findings: the program contributed to the experimental group's positive attitude toward death, and improved end of life care performance. Limitations: small homogeneous sample from one nursing school in Korea. No mention of ethics approval.
Caly and Tamlyn (1984) Canada Active Learning Strategy	1) Do nursing students' attitudes toward death and dying change significantly after a death education seminar? 2) After completing a death education seminar, do nursing students who have experienced the death of an immediate family member register a more significant attitude change than those who have not? 3) After a death education seminar, do nursing students who have nursed dying patients have a more significant attitude change than nursing students who have not?	Experimental group: 33 senior nursing students (83%); Control group: n = 22 senior physiotherapy students (86%).	Treatment group: 2 day (16 h) death and dying seminar; Day 1: "Death and Me"; loss and grieving, personal experiences with death and dying, spiritual aspects of death and dying, film "Jacobry"; Day 2: "Death and Nursing": Hospice discussion, communication, group discussion/case study/role play. Control group: no formal required course or planned content on the topic of death and dying.	Quantitative: Quasi-experimental design; Pre-test/Post-test. Instruments: -Questionnaire for Understanding the Dying Person and His Family- pre and post seminar. -Written exam questions, verbal evaluation and measurement of attitudinal change.	Findings: Statistically significant difference in mean scores between pretest and post-test (14 months) in the experimental group supports improved attitudes in nursing students. -Statistically significant difference in the mean scores between the two groups at post-test; test supports the value of this two day seminar. Limitations: Small sample size from one university, 30% difference in experimental and control group size.
Lockhard (1989) USA Active Learning Strategy	1) Is there a significant difference between the Death Anxiety Scale (DAS) post-test scores of the two groups? 2) Is there a significant difference between the DAS post-test scores of students in both groups? 3) Is there a significant difference between the DAS follow-up test scores of students from both groups? 4) Is there a significant relationship between pretest DAS scores and the age, death experience, or nursing experience of subjects? 5) Is there a significant relationship between the experimental group's change in DAS from pretest to follow-up test, and their age, death experience, or nursing experience? 6) Is there a significant relationship between the experimental group's change in DAS from posttest to follow-up test, and their age, death experience or nursing experience?	74 students (all female) completed post-test; 50 students at follow-up test after 1 year.	Intervention: 7 h death education program over 2 weeks: classes on grief and loss, lectures on communication, discussions on personal experiences, values clarification exercises, audio-visual aids. Control procedures: not discussed.	Quantitative: study design not clear (experimental design- pretest, post-test, post-post-test). Instruments: Death Anxiety Scale (DAS) (pretest, post-test, post-post-test and follow-up at 1 year).	Findings: The death education was effective in reducing the death anxiety level (immediately after, 4 weeks later and 1 year later). Experimental group students with previous nursing experience were less likely to have a positive change in death anxiety level than those with no previous nursing experience. Strengths: Random assignment into experimental and control groups. Limitations: Student's level of study not disclosed, nos in control and experimental groups not clear. No mention of ethics approval.
Wong et al. (2001) Hong Kong Experiential Learning Strategy	1) What are the behaviour and attitude of nurses towards death and dying at the beginning of the course? 2) What changes does PBL bring about in educating nurses in caring for the dying? 3) What are the particular learning effects that have resulted from different problems?	72 sets of journals of senior students enrolled in the "Applied Psychology course"	PBL involving three case based scenarios with three different problems	Qualitative: Case analysis of participant journals. Data collection: Journals	Three themes were identified: 1) Nurses acknowledging their emotions when facing death and dying 2) A need for nurses to be better equipped in communication and counselling 3) A holistic and family centred approach to care. -PBL helped students deal with death and dying issues in a positive manner and to contemplate the care of the dying from different dimensions. Limitations: No participant characteristics, students from one university in Hong Kong. No mention of ethics approval.
Mok et al. (2002) Hong Kong Experiential Learning Strategy	Purpose of research: to monitor the effectiveness of PBL using case analysis	96 participants (Bachelor of Science in Nursing- conversion degree)	PBL involving three case based scenarios with four different problems	Qualitative: Case analysis of participant journals. Data collection: Journals	Three themes were identified: 1) Increased self-awareness 2) Positive attitudes towards death 3) Providing culturally sensitive care -The study supports the use of PBL in teaching students about death and dying. -Students felt that they acquired knowledge and communication skills. Limitations: No systematic observations of the communication and counselling skills of the nurses; No participant characteristics, study limited one university in Hong Kong.
Hurtig and Stevin (1990) Canada Experiential Learning Strategy	1) How can nurse educators help students to face death related fears before they come to the bedside of the dying patient?	23 experiential group; 27 didactic group; 26 in control group; junior nursing students (no clinical experience). Total = 76 participants.	Didactic group: formal lectures, films and group discussion; Experiential group: death awareness exercises, music, drawing and dyadic encounters between students; Placebo group: simulation game on the aging adult, lecture and discussion.	Quantitative: Experimental study comparing the effect of programmes (didactic, experiential and placebo). Instruments: -Confrontation-Integration of Death Scale (CIDS) -Evaluation form (open-ended questions).	Findings: an experiential program was more effective than a didactic approach for students without personal death experience to confront feelings and thoughts concerning death. Limitation: small sample sizes in each of the groups. No participant characteristics. Unclear if variables and covariates were considered and controlled. No mention of ethics approval. Strengths: Self-selection was controlled by incorporating the treatment into the required psychology course. Random assignment into 3 different experimental groups.
Kwekkeboom et al. (2005) USA Experiential Learning Strategy	No research question. Aims of program: to provide companionship to patients while providing an experiential learning experience in end of life care.	34 (19 companions; 15 controls) – two semesters.	Experimental group: Volunteer Palliative Care Companion Program: 1) 2 h orientation (second semester also included 2 h individual "shadowing" orientation). 2) Companion service-patient visits 3) Optional education-viewing film ("On our Own Terms") video series; hospice support groups and education; newsletters Control group-not discussed.	Quantitative: Quasi-experimental controlled pre-test-post-test design. Instruments: 1) Demographic questionnaire; 2) Palliative Care Quiz for Nurses; 3) Attitudes About Care at the End of Life; 4) Concerns About Caring for Dying Patients	Findings: Knowledge scores for all participants improved – companions scores were significantly higher than controls. -companions reported more positive attitudes, fewer concerns, more confidence and less apprehension in caring for dying patients at the end of semester. Limitations: Small sample size; Self-selection of students.
Kwekkeboom et al. (2006) USA Experiential	1) Do knowledge, attitude and concern scores of palliative care companion subjects improve significantly after participation in the semester long program? 2) Do knowledge, attitude and concern scores	52 (32 companions; 20 controls) nursing students	Experimental group: Volunteer Palliative Care Companion Program with 2 orientation sessions (2 h orientation and shadowing experience).	Mixed methods study: controlled pre-test-post-test design, qualitative analysis of journals.	Findings: The palliative care companion program produced a significant decrease in concerns about caring for dying patients among companion students. -Combining didactic with clinical

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Table 3 (continued)

Author/s year/country	Research question	Sample	Educational intervention	Research design/methods	Key findings
Learning Strategy	of palliative care companion subjects improve more than those of their student peers not participating in the companion experience? 3) What types of activities do the palliative care companion subjects engage in to facilitate their own learning experiences?		Control group: completed regular undergraduate nursing program activities.	Instruments: 1) Demographic questionnaire 2) Palliative Care Quiz for Nurses (PCQN) 3) Attitudes About Care at the End of Life 4) Concerns About Caring for Dying Patients (CAD) 5) Participant journals 6) Post experience information—describe other experiences that may have influenced knowledge and opinions of palliative care.	experiences resulted in the most positive learning. Limitations: -Sample size small with fewer controls than experimental. -Problems with internal consistency of the PCQN and the measures for attitudes towards Palliative care. -Some students reported other experiences that may have influenced their knowledge and opinions about palliative care. -Students self selected into palliative care companion program.
Liu et al. (2011) Taiwan Experiential Learning Strategy	No Research Question. Research aim: to learn what nursing students experienced during a workshop on life and death issues and how they reacted when they imagined facing their own death.	Sample: n = 20, 11 of 1st year, 9 of 2nd year with no experience caring for a dying patient.	Experiential workshop: two 3 h sessions; Session 1: participants imagined that they had 30 min to live—letter writing exercise. Session 2: participants asked to write their own epi-aph (90 min small group discussion).	Qualitative study: Interpretive descriptive design, using thematic analysis. Instruments: -Student's reflective journals -workshop evaluations—researchers field notes on observations during small group discussions.	Findings: Students experienced a dying-death-rebirth process. This study provided students with an understanding of reflections on life and death. Major themes identified: 1) Surprise at discovering they had only 30 min to live 2) Reluctance to let go—facing death. 3) Genuineness for what they had experienced in life. 4) Importance of cherishing the present. 5) Professional commitment—to the nursing profession. 6) Pondering the value of life—students came to understand the meaning of life based on the management of their own lives. Strength: Random assignment into one of two groups. Limitations: small convenience sample of young inexperienced Asian students. Findings: A Pearson χ^2 analysis revealed a significant relationship between previous death education and attitudes toward care of the dying. -A significant positive increase in the attitudes of nursing students toward care of the dying was seen, when compared with the control group. Limitations: -The FATCOD did not identify all previous death experiences and death education was limited to the attitudes that students were aware of or were willing to report. -Researcher as instructor—may have introduced bias. -Asking students on pretest about attitudes toward caring for dying patients could affect attitudes on post-test. -Non-random selection.
Mallory (2003) USA Experiential Learning Strategy	1) Will there be a significant difference in attitudes toward care of the dying in nursing students who participated in didactic and experiential education and those who did not? 2) Will there be a change in attitudes toward care of the dying in nursing students who participate in palliative care education component? 3) Is there a relationship between nursing students' attitudes toward care of the dying and their previous education on death and dying? 4) Will there be a difference in attitudes toward care of the dying in nursing students comparing post-test to post-post-test?	Pretest: 104 junior level undergraduate nursing students (Intervention: n = 45; Control: n = 59). Post-test: n = 95 (Intervention: n = 41; Control: n = 54); Post-Post-test: Intervention: n = 36. Participants from 2 nursing schools—one used as control and one as intervention.	Intervention: Palliative care educational component of didactic and clinical experiences (6 week program). Control group: no treatment. ELNEC content: lectures/discussion on palliative care, death and dying and pain management, small group discussions and role play in a seminar format, visited gross anatomy cadaver lab, visit to funeral home to learn about post mortem care, burial options and bereavement services, spent a day at hospice observing hospice nurses, the interdisciplinary team and patients.	Quantitative: Quasi-experimental, longitudinal design, with pretest, intervention and double post-test (4 weeks post intervention) format. Instruments: -FATCOD.	-Participants from small region in the US. -Limited information on the difference in the two groups (the control had more death experiences and education). Findings: the experimental group had a change in overall attitude and fear of death and dying was reduced in regard to death and dying. -Scores of the control group unexpectedly increased overall. Limitations: a subsample of comparison group attended an anatomy lab prior to completing the instrument for the second time, that may have affected the post-test scores. -No mention of Ethics approval. -Limited statistical analysis (mean and standard deviations only). -No mention of level of student. Strength: Australian study.
Mooney, 2005 (Australia) Experiential Learning Strategy	No research question. Aim of research: to examine the effectiveness of a death education program in reducing the death anxiety in Australian undergraduate nursing students.	Experimental group: 115 students completed the pretest scale, n = 97 pre and post matched data sets. Comparison group: 128 students completed the pretest scale, n = 122 control group pre and post matched data sets.	Experimental group: single semester death education program (39 h over 13 weeks) experiential/didactic: weekly 1 h didactic lecture and 2 h of exercises and activities on life and death issues using reflection and journaling. Comparison group: enrolled in a similar program.	Quantitative: Quasi-experimental non-equivalent control group design (Pretest/Post-test). Instruments: -The Lester and Abdel-Khalak version of the revised Collett-Lester Fear of Death Scale.	Findings: the experimental group had a change in overall attitude and fear of death and dying was reduced in regard to death and dying. -Scores of the control group unexpectedly increased overall. Limitations: a subsample of comparison group attended an anatomy lab prior to completing the instrument for the second time, that may have affected the post-test scores. -No mention of Ethics approval. -Limited statistical analysis (mean and standard deviations only). -No mention of level of student. Strength: Australian study.
Hutchison and Scherman (1992) USA Experiential Learning Strategy	Hypothesis: that the experiential group would show greater reduction in death anxiety than the didactic group and that the reduction would not be apparent until 8 weeks after training.	Sample: 74 female 1st year nursing students from 3 nursing schools in Oklahoma; Didactic group: 44 students (5 did not complete post-test); n = 39 students; Experiential group: 30 students (4 did not complete post-test); n = 35 students.	Intervention: Didactic group: 6 h workshop (lecture, visual aids, and large group discussions) stages of grief, awareness of dying; communication styles; phases of post-bereavement grief; tasks of mourning. Experiential group: 6 h workshop; exercises exploring personal experiences with death and grief.	Quantitative: Pretest-post-test analysis of covariance study with two groups. Type of death and dying training and occasion used as independent variables. Instruments: -The Templer Death Anxiety Scale (DAS) -Thematic Apperception Test (TAT) -Experiential group post-test (2 days and again 8 weeks after workshop).	Findings: Hypothesis was not supported. There were no differential effects of didactic versus experiential training at post-test or follow-up. The study found that training, regardless of type, reduced self-reported death anxiety on a small scale. Limitations: inability of the investigator to eliminate an experiential component from the didactic training. -No mention of ethics approval.
Wallace et al. (2009) USA Education Initiatives	No Research Question. Purpose of project: to report on end of life knowledge and experiences of two groups of nursing students in one small liberal arts university.	Sample: n = 111 undergraduate students (61 sophomores, 50 seniors) Questionnaires returned: 38 sophomores and 40 seniors.	Intervention: ELNEC curriculum content. Teaching strategies: discussions on death experiences, asking patients of symptom experiences, ethical issues related to access to end of life care. Opportunity for hospice care and clinical conferences on end of life care issues.	Possibly Mixed Methods-study design is not described. Instruments: -Demographic questionnaire -Short qualitative questionnaire. -ELNEC 50 item knowledge pretest: to determine baseline knowledge of EOL care.	Findings: End of life knowledge increased throughout the curriculum, however there was still limited competence in palliative care. Limitations: limited by small homogeneous sample and only one sampling site.
Barrere et al. (2008) Education Initiatives	1—Does the integration of the ELNEC curriculum into a BSN program affect the attitudes of undergraduate nursing students toward care of the dying? 2—Is there a difference between traditional BSN students' and accelerated BSN students' attitudes toward care of the dying before and/or after the integration of the ELNEC curriculum into the programs? 3—What factors affect students' change in attitude toward care of the dying after integration of the ELNEC curriculum into a BSN program?	Sample: 103 senior nursing students (61 traditional, 42 accelerated) were invited to participate. Participants: n = 73 senior level baccalaureate nursing students (39 (53%) traditional; 34 (47%) accelerated) during the students last semester of the senior year participated.	Intervention: Integration of the ELNEC curriculum content	Quantitative: Quasi-experimental Pretest/Post-test longitudinal repeated measures design. Instruments: completed at the beginning and end of the professional component of their nursing program. 1) Demographic questionnaire at the beginning of the study. 2) FATCOD	Findings: No previous experience with the terminally ill was the strongest predictor of a change in attitude from the beginning to the end of the program. -A younger age was the next strongest predictor of change, those aged 22–25 years had the strongest change in attitude. -ELNEC education program positively affected the attitudes of nursing students toward care of dying patients. Limitations: small convenience sample from one university, no control group, race, culture and ethnicity were not examined.

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Table 3 (continued)

Author/s/ year/country	Research question	Sample	Educational intervention	Research design/methods	Key findings
Dobbins (2011) USA Active Learning Strategy/ Education Initiatives	No Research Question. Study purpose: to evaluate the impact of an ELNEC elective course on attitudes of students toward death and caring for the dying and to evaluate the effect of an end of life module on the attitudes of a similar group of students.	Sample: Study 1 – Experimental group: n = 12 (all students enrolled in an elective “Nursing Care at the end of life” course). Control group: n = 25 (students enrolled in a required advanced medical/surgical course “Nursing Process 3” with a 3 h end of life module). Study 2 – Experimental group n = 16 (all students enrolled in the elective course). – Control group n = 22. (All samples from one community college in a semi-rural area of the southeast USA).	Experimental: ELNEC Powerpoints, supplemental text, visit to hospice and funeral home, and viewed film Wit. Control: Powerpoint lecture (3 h ELNEC end of life module, discussion, reference medical-surgical text). (Study 2, control group also required to view film Wit).	Quantitative: A quasi-experimental study design. Pretest/Post-test: (14 weeks post). Instruments: -Demographic data -Death Attitude Profile-Revised (DAP-R); -FATCOD.	issues with inability to match some pre and post questionnaires; the self reporting nature of the data collection instrument and no opportunity for students to provide additional responses. Findings: students benefited from both courses. -both groups from both studies, decreased their fearful thoughts and feelings about death and dying, decreased purposeful avoidance of thinking about death, and increased acceptance of death. -All but the students in Study 1 control group demonstrated an increased acceptance of the inevitability of death. -Scores of the FATCOD reflected an improvement in attitude toward caring for the dying in all but the study 1 control group, both intervention groups increased their scores significantly. Study 2 control group with the end of life module plus viewing Wit, had a significant impact on the fear of death subscale and approached significance on the FATCOD, suggesting a decrease in fear of death and an increase in comfort for caring for dying patients. The results of this study suggested that the ELNEC based elective course significantly decreased aspects of death anxiety and improved student's attitudes towards caring for dying patients. Results also support the use of “cinemedication” as a teaching strategy. Limitations: Small sample size from one institution, level of study not clear; Study 2 included the film Wit to the control group – this may limit the results of the intervention for this study.
Weissman (2011) USA Education Initiatives	Research questions: 1) Do students receiving the communication module have improved self-efficacy levels in communication skills compared to the group not receiving the communication module? 2) Are there significantly more positive attitudes based on FATCOD in the group receiving the communication module compared to the group not receiving the communication module?	Sample: Intervention group: n = 9; Control group: n = 8; 1st year nursing students attending a private university across multiple campuses, enrolled in “Basic Adult Health” course.	Control group: course module on end of life care, usual didactic lecture powerpoint, case study, group discussion and clinical placement. Intervention group: same course module as well as the ELNEC communication module (of 2.5 h, 25 powerpoint slides on communication). Modules: Experiential modalities; letter to “Dear Death”; sensitisation exercises by viewing videos such as “In the Gloaming”; Attentive listening exercises; “Eliciting End of life goals” role-plays.	Quantitative: Pilot study with a pretest, post-test; quasi-experimental design. Instruments: 1) VAS used to measure self-efficacy or confidence. 2) FATCOD Pretest/Post-test 3) Demographic data 4) background data 5) post-test: both groups were asked of “any clinical experiences with a dying patient since completing the previous survey?” 6) intervention group also asked to describe learning experiences with the communication module.	Findings: Both groups reported greater confidence in ability to communicate with a dying patient on the post-test. Both approaches to teaching were associated with positive changes in self-efficacy in communicating with dying patients, whereas the ELNEC curriculum was associated with substantial improvement in attitudes. Limitations: small convenience sample (sample was too small to relate the variables to having a significant impact on the student's attitude toward care of the dying), the intervention was introduced by the researcher who is also program director, which may have resulted in potential bias in the groups responses.
Bush (2012) Australia Education Initiatives	Study aims: to determine if the completion of a Oncology and Palliative care elective course aided a group of undergraduate nursing students in the clinical provision of palliative care.	Sample: 70 students who had recently completed the Oncology and Palliative Care Course at a Victorian University were randomly selected and sent to questionnaires. 51 returned.	Intervention: A single semester Oncology and Palliative Care Course guided by RCEU outlines and recommendations, delivered for 3 h each week.	Mixed Methods: Descriptive/explorative mixed methods study (only results of phase 1 of study available). Instruments: -Survey/questionnaire with qualitative comments. -Demographics.	Findings: Students perceived an ability to be clinically competent in the facilitation of Palliative care following an elective course in palliative care. The course had a positive influence on students learning of palliative and end of life care. Limitations: small sample size, limited to a 3rd year cohort from one university, participant self-selection into elective course indicates a potential bias towards palliative care. Strength: Australian research.

There are a number of quantitative studies that sought to assess the effects of various experiential educational programs on end of life care. These studies include experimental studies (Hurtig and Stewin, 1990; Hutchison and Scherman, 1992), quasi-experimental studies (Kwekkeboom et al., 2005; Mallory, 2003; Mooney, 2005), and a mixed methods study (Kwekkeboom et al., 2006). The findings from these studies provide mixed results. In an early study, Hurtig and Stewin (1990) used an experimental study with random assignment into one of three experimental groups (didactic group $n = 27$, experiential group $n = 23$, control group $n = 26$) to investigate the effect of a death education program and personal experience with death on the attitudes of nursing students. Two way analysis of Confrontation-Integration of Death Scale (CIDS) scores indicated that neither the death education treatments nor personal experience independently produced a significant variation in death confrontation or death integration scores. Hutchison and Scherman (1992) compared the effectiveness of didactic teaching with experiential death and dying education on the reduction of death anxiety measured by the Templer Death Anxiety Scale (DAS) and the Thematic Apperception Test (TAT) in a cohort of female nursing students ($n = 74$ 1st year nursing students, didactic group $n = 39$, experiential group $n = 35$) from three nursing schools in the USA. This study found that education, regardless of type, did reduce self-reported death anxiety, although the change was small.

More recently, Mallory (2003) used a quasi-experimental, longitudinal design with a pretest, intervention (didactic and clinical experiences), and double post-test format to examine the impact of a palliative care educational component on the attitudes toward care of the dying (measured by Frommelt's Attitudes Toward Care of the Dying Scale) in junior undergraduate nursing students from 2 nursing schools in the USA (Pretest $n = 104$; Post-test $n = 95$; Post-post-test $n = 36$). This study concluded that nursing students' attitudes toward caring for dying patients improved after an experiential educational component in palliative care. In the only Australian study on experiential learning in end of life care, Mooney (2005) conducted a quasi-experimental non-equivalent control group design and used a didactic/experiential approach to measure the effectiveness of a death education program in reducing death anxiety in undergraduate nursing students (experimental group $n = 97$, control group $n = 122$ pre and post-test matched data sets). Findings from this study further support a death education program as effective in reducing death anxiety.

In summary, experiential learning strategies provide students with opportunities to integrate knowledge and experience and promote meaningful learning experiences through reflection. An important finding is that no previous personal experience may be a significant variable (Hurtig and Stewin, 1990). There was a significant relationship between previous death education and attitudes towards care of the dying (Mallory, 2003). The lessons learned from these studies include that end of life education should involve a combination of both clinical experiences and didactic approaches for a comprehensive end of life care learning experience. It also suggests that experiential programs can be effective in reducing death anxiety, especially when the program allows individuals to examine and resolve attitudes and beliefs over time rather than a short intensive program (Mooney, 2005). Despite these lessons, the findings from these studies require careful attention for the followings reasons. Firstly, the small sample size reduces statistical significance. Secondly, the reliability and validity of some of the tools used in these studies are not discussed.

End of Life Care Education Initiatives

Recent advances in end of life education by consortia such as the End of Life Nursing Education Consortium (ELNEC) from the US and Palliative Care Curriculum for Undergraduates (PCC4U) in Australia provide a combination of both active and experiential learning methods of teaching.

ELNEC is an educational program designed to improve end of life care by nurses, funded by the Robert Wood Foundation (Wallace et al., 2009). ELNEC teaching strategies include a range of interactive methods of teaching including group discussion, cumulative loss exercises, case studies, storytelling, testimonials, poetry and pictures. Several researchers' efforts to integrate these methods into their programs are notable. Barrere et al. (2008), Dobbins (2011) and Weissman (2011) used a quasi-experimental study design, while Wallace et al. (2009) used a mixed methods approach to evaluate the impact of ELNEC education content on students' attitudes towards caring for dying patients.

Barrere et al. (2008) found a significant change in attitude in students ($n = 73$) with no previous death experience ($t = -3.687$, $p = .000$). A younger age was the most powerful predictor of a change in attitude from pretest to post-test, supporting findings made by Hurtig and Stewin (1990). Dobbins (2011) conducted two separate studies (study 1 – intervention group $n = 12$, control group $n = 25$ and study 2 intervention $n = 16$, control $n = 22$) and found similar results. The authors found that the ELNEC intervention (Communication module) resulted in decreased scores in some of the Death Attitude Profile-Revised (DAP-R) subscales in both intervention groups and an increase in the FATCOD scores reflecting an increase in positive attitudes toward caring for dying patients. Weissman's (2011) pilot study of 17 of 1st year nursing students (intervention group $n = 9$, control group $n = 8$) evaluated self-efficacy in communication skills. The control group received standard didactic end of life content (traditional lecture, case study, and group discussions) while the intervention strategies included viewing selected segments of the film 'In the Gloaming' Nugiel & Reeve (1997) and discussion, active listening exercise and role-play activity. Results showed that both approaches were associated with positive changes in self-efficacy (measured by the Visual Analogue Scale for self efficacy) in communicating with dying patients (not statistically significant), however, the ELNEC curriculum was associated with substantial improvements in attitudes towards care of the dying (measured by FATCOD). Wallace et al. (2009) reports similar results and found that knowledge of end of life care increased throughout the curriculum after integration of ELNEC content into the curriculum.

In response to available evidence that suggests Australian undergraduate programs are not adequately preparing health care professionals for end of life care (Mooney, 2005; Bush, 2012), in 2005 the Australian Government Department of Health and Aging (2011) funded the PCC4U program. The PCC4U program utilises a range of engaging learning resources including video vignettes and palliative care case studies and scenarios (PCC4U, 2011). Due to the recency of this initiative, there is minimal research available on the effectiveness or use of this in Australian undergraduate nursing programs. The research conducted by Bush (2012) is the only research identified from the available literature.

Bush (2012) used a descriptive/explorative mixed method in a two phase study. The results are available from phase 1 only which aimed to determine if the completion of a Oncology and Palliative Care elective course (guided by PCC4U outlines and recommendations) on a group of 3rd year undergraduate nursing students aided in the clinical provision of palliative care. A questionnaire was sent to 70 randomly selected students who had recently completed the course with 73% ($n = 51$) response rate. The study found that all participants felt the course influenced their perceived ability to be clinically competent in the facilitation of palliative care and that the course had a positive influence on student's learning of palliative and end of life nursing care. Nevertheless, the study shares similar limitations of other studies already discussed. In addition, potential favourable bias towards palliative care also needs to be considered given that students self-selected themselves for the elective course.

The findings from these studies contribute to the existing body of literature and support the value of integration of end of life care education into undergraduate nursing curricula. The tool (FATCOD) used

in three of the studies had strong reliability and validity. However, it is important to note the limitations of the studies. The sample sizes in all five studies mentioned are small which questions statistical significance. Given that the studies were conducted in one institution with small sample size, this limits generalisability of the results. The methodological issues in study design are also important to note; no control group used in three of the studies, issues with inability to match some pre and post questionnaires in some instances and the data collection instrument of self-reporting nature (Barrere et al., 2008). Furthermore, the reduced control of variable by viewing the same film (Bosanquet & Nichols, 2001) used in the intervention groups (Dobbins, 2011) limits these findings.

Limitations

There are a number of limitations of the review that need mention. Although the search strategy included a number of search terms and databases, the search strategy may not have identified all the relevant literature on this topic, such as unpublished literature, since the review was restricted to published research studies only. The review was not restricted to English only publications, however, papers of relevance that were not in English may not have been identified. Also the focus of the paper was on teaching strategies in end of life care education, other teaching strategies may be used in practice, but not be published as research so these too may not have been identified. Nevertheless, this paper aims to be a comprehensive but not exclusive review of the current available research on end of life care education.

Conclusion and Recommendations

The literature has highlighted that nursing students feel unprepared to deal with issues related to death and dying. Research found that schools of nursing are not adequately educating nursing students to care for patients at the end of life and this has been identified as a crucial reason for inadequate care. The paper reviewed literature available to examine how end of life care education has been delivered to undergraduate nursing students and discussed the research on modes of delivery and teaching strategies utilised in end of life care education.

Issues in end of life care education highlighted in the research include lack of end of life content in textbooks and lack of content on end of life care in the undergraduate nursing curricula. The issues identified in the available research include methodological issues of sample size and the scientific quality of the tools used. Interestingly, most of the identified research are of a quantitative ($n = 12$) nature and the minority of these studies are of a purely qualitative ($n = 3$) or a mixed method ($n = 3$) nature. The gap identified is the lack of qualitative research on end of life care teaching strategies prompting a question as to how to effectively assess learning strategies for depth of learning experiences in end of life care education.

When implementing teaching strategies for end of life care education it is recommended that; 1) the level of the undergraduate nursing student; 2) the characteristics and demographics of the cohort; and 3) the experience with death and dying (either personal or professional) need careful consideration. Because undergraduate nursing student cohorts across the world vary significantly in characteristics, a number of teaching strategies are required to provide a range of learning experiences that meet all learners' needs.

Whilst many innovative teaching strategies have been implemented, using simulation on end of life education in undergraduate nursing programs appears to be an attractive option in providing quality learning experiences for undergraduate nursing students. The paucity of research on this teaching and learning strategy highlights the necessity of exploring this as an innovative means of providing meaningful experiences with end of life care and preparing students to provide quality end of

life care in clinical practice. Part 2 of this literature review will provide a critical discussion on end of life care simulation.

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7.2 Appendix B: Gillan, Jeong & van der Riet, 2014b

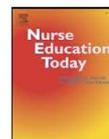
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Review

End of life care simulation: A review of the literature



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SUMMARY

Background: Simulation is an evolving pedagogical approach to teaching in many undergraduate nursing curricula, however, there is little published literature on end of life care simulation as an effective means of teaching nursing students about end of life care.

Literature review aims: To examine available literature on end of life care simulation.

Review methods: An extensive literature search on end of life care simulation in the undergraduate nursing curriculum was conducted in CINAHL, Mosby's Index, Cochrane Database, Scopus, Eric via Proquest, and Medline. 6 research articles and 10 descriptive articles published between 2009 and 2013 that met the selection criteria are included in the review.

Findings: Findings of these 16 articles are reported under 4 main themes: 1) Increased knowledge of end of life care through 'experiential learning'; 2) Impact of family presence on student learning; 3) the Debriefing imperative, and 4) Methodological issues raised from studies.

Conclusion: The findings of the studies reviewed support end of life care simulation as a strong and viable pedagogical approach to learning for its positive effects on knowledge acquisition, communication skills, self-confidence, student satisfaction and level of engagement in learning. However, the important factors including psychological safety of students and the costs involved require careful consideration. Research on the use of simulation in nursing is still in its infancy, further research using various research designs is required to adequately explore the issues surrounding end of life care simulation.

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Introduction

This article is the second part of a literature review that explores the history and future of end of life care education for undergraduate nursing students. The first paper "End of Life Care Education, Past and Present: A Review of the Literature" (Gillan et al., in press-b) explored how end of life care education has been delivered since 1984 and to the present. Two main themes 'Methods of end of life education delivery' and 'End of life care education initiatives' were highlighted. A turning point is evident in the emerging use of simulation for end of life care since 2009 in an effort to help prepare students for undertaking quality end of life care in the clinical setting.

Background

Simulation is defined as "An event or situation made to resemble clinical practice as closely as possible" (Jeffries, 2007, p. 28) and is categorized according to the level of fidelity or realism along a spectrum

of low fidelity to high fidelity. Examples of low fidelity include the use of case studies or role-plays related to a particular situation. High fidelity simulation is defined as "the use of technologically lifelike manikins with provision for a high level of realism and interactivity" (Jeffries, 2007, p. 28).

The use of simulation in nursing education dates as far back as 1874 when anatomical models were used in the form of jointed skeletons (Nehring and Lashley, 2009). The formal use of manikins to enhance student learning began a century ago with the introduction of 'Mrs Chase' a full body static manikin in 1911 (Jansen et al., 2009). However, simulation only became popular in the 1950s when it was realised that using manikins helped students put theory into practice (Roberts and Greene, 2011). In the 1960s the use of low fidelity manikins such as 'resusci-Annie' became popular, and is still in use today (Roberts and Greene, 2011).

Since 2004 the use of high fidelity manikins has increased as an effective means to teach essential skills for nursing students. High fidelity simulation is viewed as an innovative pedagogical approach (Reilly and Spratt, 2007; Berragan, 2011) in a safe clinically realistic environment (Twigg and Lynn, 2012). Simulation contributes to improving critical thinking, clinical reasoning skills and problem solving skills without fear of causing harm to actual patients (Jansen et al., 2009; Sperlazza and Cangelosi, 2009). Further benefits include; 1) improving

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knowledge acquisition (Lapkin et al., 2010); 2) promoting understanding and application of cognitive and psychomotor skills (Bland et al., 2011; Feingold et al., 2004); 3) bridging the gap between theory and practice (Kopp and Hanson, 2012); and 4) refining communication and technical skills in interdisciplinary teamwork (Jansen et al., 2009). More importantly, there is strong evidence of high learner satisfaction with the use of high fidelity patient simulation (Lapkin et al., 2010). This is significant because learner satisfaction may potentially enhance student's engagement and therefore, facilitate learning (Lapkin et al., 2010).

However, the focus of most of this research is on acute or critical care nursing using scenarios related to emergency or advanced resuscitation situations (Feingold et al., 2004). It was not until 2009 that the use of simulation in end of life care education emerged.

Aims

The aims of the literature review were to 1) explore what literature exists on end of life care simulation in undergraduate nursing education and 2) critically discuss the issues related to end of life care simulation. This paper critically reviews the literature on end of life simulation and argues for its relevance in undergraduate nursing education.

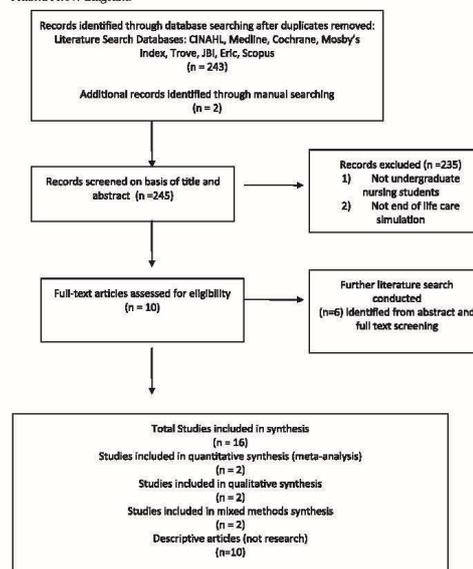
Review Methods

A search of published literature was conducted on CINAHL (Cumulative Index of Nursing and Allied Health Literature), Mosby's Index, Joanna Briggs Institute, Cochrane Database, Scopus, Eric via Proquest, Medline, and Trove. A total of 243 journal articles of potential use were identified. Key search terms and database results used are cited in Table 1. Two further articles were identified using a manual search of the relevant journals (n = 245).

These articles were reviewed for the key search terms of "end of life care"; "simulation"; "high fidelity simulation", "simulated death", "death simulation", "end of life simulation" and "nursing students". Article abstracts were reviewed for content specifically on participants (nursing students) and methodology (use of simulation). A total of 10 articles met the inclusion criteria of: 1) end of life care simulation; 2) undergraduate nursing students. The remainder 235 articles were excluded because they did not relate to end of life care, simulation or undergraduate nursing students. Table 2 provides a decision flow diagram.

A further literature search conducted in early 2013 revealed a further 6 articles, demonstrating an increased interest in this topic. A total of 16 articles have been identified of relevance and are included in the literature review. Of these only 6 were original research articles, the remainders of these are descriptive articles that report on projects undertaken in end of life care simulation, using high fidelity and hybrid

Table 2
PRISMA flow diagram.



simulation strategies. Due to the limited amount of literature on this topic all the relevant literature on end of life care simulation in nursing education are included in the review. Table 3 provides a breakdown of literature by the publication type.

The identified literature was analysed using thematic analysis by the primary author. Identified themes were confirmed by the other two authors of the review. This process of peer review ensured rigour and trustworthiness of thematic analysis.

Findings

Four main themes were identified from the literature; 1) Increased knowledge of end of life care through 'Experiential learning'; 2) Impact of family presence on student learning; 3) The debriefing imperative; and 4) Methodological issues raised from studies. Table 4 provides a summary of the key findings from the literature.

Table 1
Search terms and databases used in initial search strategy.

Search Terms:	"AND"	Database:	Number of articles identified after duplicates removed
Undergraduate nursing students/ Nursing degree students/ Bachelor degree nursing students Baccalaureate degree nursing students	End of life care/palliative care/terminal care/hospice care/hospital care/acute care/ residential aged care/nursing homes/long term care/long term aged care/geriatric care/geriatrics/grief and loss/grief and loss education/grief and loss programmes/ bereavement/ Bereavement education/bereavement programmes/Debriefing/clinical debriefing/ end of life care debriefing/death and dying debriefing/Death and dying/death/death and stress/dying patients/Death education/death curriculum/death curricula/End of life care education/end of life care curriculum/end of life care curricula/end of life education/end of life curriculum/end of life curricula/Simulation/death simulation/ simulated death/End of life simulation/End of life care simulation/High fidelity simulation	CINAHL; Mosby's index; Joanna Briggs Institute; Cochrane database; Medline; Scopus; Eric via Proquest; Trove	197 8 5 6 7 11 8 1
Total results:			243

Table 3
Types of publications.

Research articles			Non research articles
Mixed methods (n = 2)	Quantitative (n = 2)	Qualitative (n = 2)	Descriptive articles (n = 10)
Quasi-experimental mixed methods pilot study (Moreland et al., 2012)	A quasi-experimental design (Fluharty et al., 2012)	Phenomenological research (Eaton et al., 2012)	Leighton and Dubas, 2009; Leighton, 2009; Smith-Stoner, 2009a, 2009b; Sperlazza and Cangelosi, 2009; Kopp and Hanson, 2012; Gillan et al., in press-a; Tuxbury et al., 2012; Pullen et al., 2012; Hamilton, 2010.
Pilot study of a single group pre/post-test design with focus group discussion (Twigg and Lynn, 2012)	A quasi-experimental design (Swenty and Eggleston, 2011)	Focus groups (Ladd et al., 2013)	

Increased Knowledge on End of Life Care Through 'Experiential Learning'

Regardless of sample size, study design and methods, the literature reviewed report that students perceived an increased knowledge and confidence in providing end of life care. During the analysis and synthesis of the literature, the authors noted that this positive effect rely heavily on the scenario that has provided the participants with a more realistic and personal experience of dying process and imminent death.

Examination of the scenarios revealed a variety of chronic or terminal illnesses that include; middle aged woman with metastatic or advanced ovarian cancer (Leighton and Dubas, 2009; Ladd et al., 2013; Kopp and Hanson, 2012), chronic obstructive pulmonary disease (Sperlazza and Cangelosi, 2009; Pullen et al., 2012), metastatic bowel cancer (Twigg and Lynn, 2012; Gillan et al., in press-a); lung cancer (Eaton et al., 2012; Moreland et al., 2012); unspecified metastatic cancer (Tuxbury et al., 2012); HIV/AIDS (Swenty and Eggleston, 2011); expected death by cancer or AIDS and unexpected death by myocardial infarction, respiratory distress syndrome or motor vehicle accident or by action or inaction by the nurse (Leighton, 2009); and successful and unsuccessful coded scenarios (Hamilton, 2010).

The students (n = 120) in a teaching project conducted by Gillan et al. (in press-a) reported that end of life care simulation provided them with an avenue to actually witness a death in a simulated clinical practice setting and enabled them to visualise the role of the registered nurse. Similar results are reported by Kopp and Hanson (2012) that the participants (n = 45 first semester junior nursing students) experienced the management of a patient with advanced ovarian cancer facing end of life decisions over three scenes. In this instance participants perceived that insights gained from simulation could be successfully transferred to clinical practice and improved participants' understandings of interventions used in end of life care. Furthermore, quantitative and mixed method studies found an increase from pre-test to post-test scores on various knowledge instruments (Fluharty et al., 2012; Twigg and Lynn, 2012; Moreland et al., 2012).

In addition, simulation provided the students with experiential learning. In qualitative studies, Eaton et al. (2012) and Ladd et al. (2013) found that hands on learning was associated with the student's perceived learning in a non-threatening, safe, controlled environment that enhanced learning outcomes. In this instance students perceived that experiential learning took place through "action, feedback and interaction" of the simulation experience (Eaton et al., 2012, p. e6). Although not research, the student participants in Gillan et al.'s (in press-a) project also reported that simulation provided a "hands on" experience, making the caring role more realistic, while Leighton and Dubas (2009) found students reported hands on experience allowed them to synthesise information learned in the classroom.

Impact of Family Presence on Student Learning

What has become increasingly evident in the end of life care simulation is the inclusion of family in scenarios and the impact this has on student learning. Seven articles report on the use of either students or standardised actors portraying roles of family members to

add complexity to the simulation scenarios and increase realism. Standardised actors played a family member in articles by Smith-Stoner (2009b), Tuxbury et al. (2012), and Eaton et al. (2012). Eaton et al.'s (2012) study which included the roles of wife and daughter (played by actors) reinforced that the family was as important as the patient when providing end of life care.

Others have used nursing academics to play the role of either daughters (Leighton and Dubas, 2009; Ladd et al., 2013; Kopp and Hanson, 2012) or patient's wife (Pullen et al., 2012), while Twigg and Lynn's (2012) simulation included the roles of wife and daughter played by the nursing academics.

In a more creative and interactive approach, several authors utilised students portraying roles of family members. Gillan et al. (in press-a) included students portraying the roles of daughter/son and granddaughter/grandson and highlighted approaching families of dying patients as a major theme. Students were given an opportunity, by playing the role of family members, to gain an understanding of how to approach and respond to family members during the dying phase of the simulation. In a research by Swenty and Eggleston (2011), students played various family members, communicating with the nurse, these students empathetically experienced the support and comfort provided by the nurse. Participants playing unspecified family members, facilitated students learning how to care for terminally ill patients and their families (Sperlazza and Cangelosi, 2009) and students portraying the role of the wife (Fluharty et al., 2012) provided the opportunity to practice communication skills.

Whether it was the students, standardised actors or nursing academics who played family members in the scenarios, it is conclusive that the inclusion of family members is important to promote therapeutic communication, holistic and culturally competent care, allowing students the opportunity to provide support and assist the family to cope with feelings of grief.

The Debriefing Imperative

The importance of post simulation debriefing is highlighted in all of the 16 articles reviewed. In all of the reviewed articles the debriefing sessions occurred following the simulations in a format of group discussions. Debriefing sessions were audio recorded (Moreland et al., 2012) or video recorded and broadcast to remote observers (Smith-Stoner, 2009a), while some used video recordings of the simulation in the debriefing sessions to facilitate discussion (Smith-Stoner, 2009b; Gillan et al., in press-a; Moreland et al., 2012; Eaton et al., 2012).

The benefits of debriefing include; 1) an opportunity to address and affirm feelings and responses related to providing end of life care (Twigg and Lynn, 2012; Gillan et al., in press-a; Ladd et al., 2013; Tuxbury et al., 2012) as well as address concerns and fears (Sperlazza and Cangelosi, 2009); 2) reflect on their own experiences (Gillan et al., in press-a); 3) interpret feelings and responses of others (Ladd et al., 2013); 4) aid in understanding of content (Twigg and Lynn, 2012); 5) facilitate therapeutic communication (Gillan et al., in press-a); 6) facilitate reflective learning (Kopp and Hanson, 2012; Gillan et al., in press-a); and 7) allows an opportunity to discuss the difficult topic of end of life care (Tuxbury et al., 2012).

Table 4

Summary of literature findings

Author/s/ year/ country	Research question/s	Sample	Simulation procedures	Research design/methods	Data analysis	Key findings
Haherty et al. (2012) USA	1) Is there an increase in students' knowledge from pretest to posttest? 2) What is the level of students' self confidence in caring for a dying patient after the simulation? 3) What is the level of students' self-reported communication skills in working with end of life patients after the simulation? 4) Are students satisfied with the learning methodology for end of life issues and care of the dying patient?	Sample: n = 370 senior students enrolled in a medical-surgical course (convenience sample). Sample: 50.8% female; 7.8% male; mean age 27.3 years; 88.4% Caucasian; 23.5% Associate Degree, 60.5% traditional baccalaureate, 11.6% accelerated baccalaureate. Simulation experience = 64% (some experience), 26% (no experience).	Procedure: 1) Powerpoint lecture – EINEC instructor. 2) 20 min simulation, 20 min debriefing, 20 min questionnaires. Simulation: 4–5 students random assign of roles (RN, RN2, wife, observers).	Quantitative: Quasi experimental design, multi-site study (4 nursing schools in Midwestern USA). Instruments: 1) Knowledge related to end of life care instrument (content validity by 12 expert nurse reviewers). 2) Self confidence in caring for a dying patient in nursing instrument. 3) End of life communication assessment tool (content validity by 12 expert nurse reviewers). 4) Satisfaction with instructional method. 5) Demographic data.	- PASW stats 17 - Descriptive statistics (demographic variables). - T-tests and ANOVA (pretest/post-test). - Correlations (relationships between variables). - Cronbach's alpha (2 of the 4 instruments).	1) Knowledge instrument – Significant difference on post-test for all students in all programmes from pre-test (pre-test mean 7.98; SD = 1.48; post-test mean 9.15; SD = 1.12), regardless of age, gender or simulation role. The observer role had the highest changes. 2) Self confidence instrument – mean 6.86 (SD = 0.61) suggests students believed they had the knowledge and skills required. 3) Communication assessment tool – mean 4.33 (SD = 0.56) reflects that students perceived they learned how to communicate in this setting. 4) Satisfaction with the instructional method questionnaire – mean 4.07 (SD = 0.81) indicates student satisfaction with simulation. Strengths – a multi-site study. Limitations: 1) The quasi-experimental design – separate contributions of the simulation and the lecture in increasing knowledge not identified; 2) The self-reporting communication tool – unable to tell if simulation actually improved communication skills. Post simulation measurement only of communication and self confidence; 3) The reliability and validity of some measurement tools not established prior to the study. Themes: 1) Impact of family presence: the presence of family enhanced realism of the simulation; 2) value of realism: realistic nature of the experience; psychosocial needs of the patient and family enhanced realism; 3) self-efficacy: a challenging experience; faculty should consider that they had never cared for a dying patient before. Limitations: small numbers of participants.
Leighton and Dubas (2009) USA	Not research. Description of a high fidelity simulated clinical experience.	Participants: 16 students (sophomore, junior and senior); enrolled in elective course ("Caring in times of death, dying and bereavement") at one Midwestern college.	Teaching strategies: didactic methods; experiential strategies; simulation ("Simulated Clinical Experience" (SCE) End of Life Care). Scenario: simulator – middle aged woman with metastatic ovarian cancer (course professor played daughter). The scenario included death of the patient. Student preparation: patient history, notes, orders and preparation questions (one week prior to simulation). Group debriefing and evaluation.	Not research.	Nil	Themes: 1) Psychological safety of students: ensuring psychological stress is recognised and dealt with appropriately. Pre-briefing and debriefing processes are vital to promote psychological safety; 2) pre-briefing: before the simulation (preparation activities, simulator orientation); 3) debriefing: exploring feelings about the events that transpired during the simulation. Limitations: limited information on project (number of participants, roles played, little information on debriefing session).
Leighton (2009) USA	Not research. Three types of simulated death are explored; issues related to simulated patient death; psychological safety of students.	No sample	Three types of patient death simulated: 1) expected death; 2) unexpected death: may come as a surprise and may be the result of a crisis; 3) death as a result of an action or inaction by the student.	Not research.	Nil	Themes: 1) Psychological safety of students: ensuring psychological stress is recognised and dealt with appropriately. Pre-briefing and debriefing processes are vital to promote psychological safety; 2) pre-briefing: before the simulation (preparation activities, simulator orientation); 3) debriefing: exploring feelings about the events that transpired during the simulation. Limitations: limited information on project (number of participants, roles played, little information on debriefing session).
Smith-Stoner (2009a) USA	Not research. Description of web based broadcasting.	Context: A rural nursing programme, faculty and students across 2 counties (Southern California).	Simulations have focused objectives Debriefing: video of work used as a learning tool; broadcast to remote participants. Remote observers: chat room	Not research.	No analysis	Themes: 1) Psychological safety of students: ensuring psychological stress is recognised and dealt with appropriately. Pre-briefing and debriefing processes are vital to promote psychological safety; 2) pre-briefing: before the simulation (preparation activities, simulator orientation); 3) debriefing: exploring feelings about the events that transpired during the simulation. Limitations: limited information on project (number of participants, roles played, little information on debriefing session).

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Table 4 (continued)

Author/s/ year/ country	Research question/s	Sample	Simulation procedures	Research design/methods	Data analysis	Key findings
Smith-Stoner (2009b) USA	Not research. Report on the experience of caring for a simulated patient who dies and interacting with a family member (standardised actor).	Sample not described.	sessions; responses and questions discussed during debriefing. Pre-simulation: selected readings, poetry. Experiential strategies and simulation. Simulation – last 10 min of life: groups of 10 (in pairs); others observers. Post simulation – reflection in writing, debriefing: reactions to simulations, evaluation of care. Evaluation: completion of CAD. 2 hour pilot simulation. Scenario: three scenes: over 4 weeks; 1–2 students played the nurse (others played other roles or as audience). Roles changed each scene. Scene 1: ED with acute exacerbation of COPD symptoms; rapid deterioration; no ACD; patient intubated; family dynamics; Scene 2: patient on ward escalated, symptoms of end of life; caregiver stress; patient advocacy; Scene 3: patient actively dying at home (last breath not drawn). Example scenarios: 1) unexpected code (successful); 2) rapid deterioration and unsuccessful code, family present.	Conceptual framework: an author-developed conceptual model ("Silver Four" – 30 min before and after death). Instruments: 1) Concerns About Dying Scale (CAD). Method: Nursing Education Simulation Framework (Jeffries, 2007) used to integrate end of life content.	None.	Limitations: limited information on simulation (numbers of participants, roles played, scenario). Physical limitations in the simulation of death – e.g. skin temp or colour cannot change, advanced programming to simulate respiratory changes.
Sperlaza and Cargelosi (2009) USA	Not research. Description of simulated clinical experience using high fidelity simulators.	Participants: n = 30 first year students (groups of 4–6), from a rural community college (ELNEC curriculum).	Simulation: advanced ovarian cancer patient (end of life decision making); 3 scenes (3 hour simulation) – 1) Assessment and admission (modelled by RNs). 2) End of life decisions (modelled by RNs). 3) Physiological changes. After death of the patient the RN's role played care of the patient and family (faculty played role of daughter). Preparation for simulation – 4 EOL related questions. Gaming simulation – groups of 4–5 played scenes of face board game. Simulator: 15/60 simulation sessions (filmed), in groups of 4–5, roles of primary nurse, secondary nurse, nursing assistant, social worker and a recorder. NP in a hospice setting played by RN. Wife and daughter played by actors. Debriefing: critique of the filmed scenario. Written responses to 2 open ended questions. Following placement: 1 follow-up open-ended question.	Framework for interaction with students developed, piloted and evaluated.	None	Evaluations revealed the need to prepare students for simulation experience, including the nature and possible impact of the simulation.
Hamilton (2010) USA	Not research.	No sample.	Example scenarios: 1) unexpected code (successful); 2) rapid deterioration and unsuccessful code, family present.	Not research	None	Themes: Debriefing and "Debriefing" are important. The Death Attitude Profile-Revised (DAP-R) as effective in addressing how well death is accepted. CAD Scale: effective in identifying students with high levels of anxiety and concerns about their own mortality. Students felt they had a better understanding of the interventions, communication techniques and what to expect with their first patient death. Importance of caring and providing comfort to the patient and family. Gaming – students developed awareness of the issues related to terminal illness, the losses people suffer and the effects of those losses. Students felt they could transfer insights gained to real clinical situations. Limitation: No discussion on the quantitative results from the Likert scale.
Kopp and Hanson (2012) USA	Not research. Report on high fidelity simulation and a gaming simulation in an "Aging adult health course".	First semester junior students (n = 36–45).	Simulation: advanced ovarian cancer patient (end of life decision making); 3 scenes (3 hour simulation) – 1) Assessment and admission (modelled by RNs). 2) End of life decisions (modelled by RNs). 3) Physiological changes. After death of the patient the RN's role played care of the patient and family (faculty played role of daughter). Preparation for simulation – 4 EOL related questions. Gaming simulation – groups of 4–5 played scenes of face board game. Simulator: 15/60 simulation sessions (filmed), in groups of 4–5, roles of primary nurse, secondary nurse, nursing assistant, social worker and a recorder. NP in a hospice setting played by RN. Wife and daughter played by actors. Debriefing: critique of the filmed scenario. Written responses to 2 open ended questions. Following placement: 1 follow-up open-ended question.	Not research Framework: Doerr and Murray (2008) "Simulation Learning pyramid".	The teaching strategy evaluated with 2 questions (5 point Likert scale).	Students felt they had a better understanding of the interventions, communication techniques and what to expect with their first patient death. Importance of caring and providing comfort to the patient and family. Gaming – students developed awareness of the issues related to terminal illness, the losses people suffer and the effects of those losses. Students felt they could transfer insights gained to real clinical situations. Limitation: No discussion on the quantitative results from the Likert scale.
Eaton et al. (2012) USA	What are the perceived influences of an end of life simulation on senior level BSN students' home health and hospice practicum experience?	Participants: n = 10 senior level students (30 students invited to participate).	Simulation: advanced ovarian cancer patient (end of life decision making); 3 scenes (3 hour simulation) – 1) Assessment and admission (modelled by RNs). 2) End of life decisions (modelled by RNs). 3) Physiological changes. After death of the patient the RN's role played care of the patient and family (faculty played role of daughter). Preparation for simulation – 4 EOL related questions. Gaming simulation – groups of 4–5 played scenes of face board game. Simulator: 15/60 simulation sessions (filmed), in groups of 4–5, roles of primary nurse, secondary nurse, nursing assistant, social worker and a recorder. NP in a hospice setting played by RN. Wife and daughter played by actors. Debriefing: critique of the filmed scenario. Written responses to 2 open ended questions. Following placement: 1 follow-up open-ended question.	Qualitative: phenomenological approach using Colaizzi framework: simulation modelled after Jeffries (2005) framework.	Data analysis: Colaizzi's method.	Strengths: Students required to deal with family conflict in regard to cultural beliefs; rigorous process of data analysis involving several steps and reading of transcripts 6 times. Trustworthiness: Confirmability established through an audit trail; the researchers bracketed bias concerning previous experience with elements related to the scenarios, home health and hospice. Transferability achieved through data saturation and an audit trail of the emerging themes. Limitations: All three researchers were course instructors – possible bias in data collection

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Moreland et al. (2012) USA	Does a simulation experience affect students' knowledge and self-efficacy related to care of the dying?	Participants: 14 junior students enrolled in a medical/surgical course from a private institution in the Northwest US (15% participation rate; 11 traditional, 3 accelerated; 13 females, 1 male; average age 20.8 years).	Pre-simulation briefing: (completion of pre-test instruments) participants listened to pre-recorded shift report; lab orientation. Simulation: initial assessment, the simulation exhibited changes in breathing at predetermined times, and deteriorated until the patient stopped breathing. Debriefing: recorded, post-simulation interview guide, viewing recording.	Mixed methods: Quasi-experimental design (pretest/posttest/pilot study). Instruments: Knowledge Assessment Instrument (author developed). Self-efficacy instrument. Posttest instruments sent by email the following day allowing for reflection.	Scores on the knowledge assessment instrument were tallied and averaged. T-tests to compare pre and post-test scores. Content analysis of qualitative comments from recorded debriefing session.	Knowledge: significant improvement (74% mean = 5.21; pre-simulation to 85% mean = 6.0 post-simulation, p = .003). Self-efficacy: a t-test showed that self-efficacy improved significantly post simulation (35.36 pre-simulation to 37.79 post-simulation, p = .05). Themes: 1) caring vs curing – difficulty with changing perspectives from curing to caring; 2) big picture – providing palliative care and the importance of this; 3) great expectations – expectation conflicts (role, performance, self-efficacy, the global experience). Conclusions: the data supports the hypothesis that student knowledge and self-efficacy increased following simulation. Limitations: small sample size.
Twigg and Lynn (2012) USA	1-Is there a change in students' knowledge toward end of life care after a simulated experience using a human patient simulator? 2-Is there a change in students' emotional readiness in providing end of life care after a simulated experience using a human patient simulator?	Pilot study: n = 16 (convenience sample of senior BSN students) from a large nursing school located in the Mid Atlantic region.	Intervention: viewing movies dealing with end of life care and group discussion on the nursing role in end of life care. Simulation: 2 groups of students providing care to patient with bowel cancer, who dies (one observer and one participant – roles reversed after first simulation). Simulation roles: primary care nurse, new graduate nurse, palliative care nurse, social worker and clergy (faculty played patient's wife and daughter). Family dynamics – daughter in denial, family conflict.	Mixed methods: single group pretest/posttest design. Focus simulation and completed the posttest: knowledge and CAD scale).	Independent variable: simulation experience with end of life care. Dependent variables: students' knowledge and emotional readiness to provide care to a dying patient.	Strengths: Validity of CAD discussed. Emotional readiness: no differences existed between students with experience and the CAD scale domains (p > .05). Men reported less stress and anxiety related to death when compared with women before the intervention (1 = -2.906, p = .012) and after the intervention (1 = -2.558, p = .023). The simulation approach increased stress and anxiety among some students (students not previously exposed to this content). Students were also in their final semester of nursing and were expected to enter the nursing profession as BSN within 6 months. Debriefing: allowed students to discuss their feelings and aided in understanding content. Limitations: single group approach increases the threats to the study's internal validity; small convenience sample.
Ladd et al. (2013) USA	No clear research question	35 (three groups) 100% participation rate.	One day programme (didactic teaching, role playing, and simulation). Simulation – death of Mrs Anderson (Hospice inpatient); 4 scenarios each followed by debriefing. 12 h of simulation (three 4 hour sessions of 4 scenarios). 4 scenarios: 1) Perioperative care. 2) Patient with lymphoma. 3) A patient with a bleeding ulcer. 4) A 50 year old patient with HIV and death of the patient (played by lab coordinator, family roles played by	Qualitative: pre class focus group (semi-structured group interview) and post class focus groups.	Content analysis of field notes and transcriptions.	Themes: avoiding the subject; witnessing pain and suffering; finding comfort in memories of a 'good death'; students felt that the simulation experience should precede clinical experience. Limitations – one instructor withdrew at the last moment, affecting students participation.
Sweeny and Eggeston (2011) USA	1) Do students perceive that active learning is present during simulation? 2) Is active learning important to the student during simulation? 3) Does the student's perception indicate that fidelity is present in the simulation?	Participants: n = 79 students enrolled in 3rd year medical-surgical unit (90% female; average age of 23.8 years) from a Midwestern public university.	12 h of simulation (three 4 hour sessions of 4 scenarios). 4 scenarios: 1) Perioperative care. 2) Patient with lymphoma. 3) A patient with a bleeding ulcer. 4) A 50 year old patient with HIV and death of the patient (played by lab coordinator, family roles played by	Quantitative: quasi-experimental pretest/posttest design. Instruments: 1) The Educational Practices in Simulation Scale (EPSS). 2) The Simulation Design Scale (SDS) – (construct validity by	ANOVA tests (to answer each research question). Turkey's post-hoc test for significant F ratios to identify pair wise differences between the means for each simulation. A power analysis for all F-ratios	Students perceived the presence of active learning, presence of fidelity, satisfaction with learning and self-confidence with learning was higher for the HIV scenario than the other 3 scenarios. Limitations: sample – from one nursing course at one university; student roles were not formally tracked (correlations

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Table 4 (continued)

Author/s year/ country	Research question/s	Sample	Simulation procedures	Research design/methods	Data analysis	Key findings
	4) Is fidelity important to the student during simulation? 5) Were students satisfied with the simulation experience? 6) Was self-confidence positively affected by the simulation?		students). Part 1 – assessment and communication. Part 2 – 10 years later, dying of AIDS (Sim Man). 4–5 students played roles as nurses, family members, and observer who took notes, shared during the debriefing session.	10 simulation experts). 3) The Student Satisfaction with Learning Scale – (content validated by 9 clinical experts). 4) The Self-Confidence in Learning Using Simulations Scale (content validity by 9 clinical nursing experts).		could not be made between the student roles and the student responses); self-reporting of surveys considered Students perceptions only.
Tuxbury et al. (2012) USA	Not research – pilot project. Goal – to evaluate the use of live actors, as both patient and family members in an end of life simulation.	N = 45 (2 active participants, 43 observers – second semester medical-surgical course).	Simulation and group debriefing: 54 year old Jewish woman with metastatic cancer hospice patient (patient played by theatre professor, daughters played by theatre students), faculty and students playing roles of nurses.	Not research	Anonymous evaluations: Quantitative – 13 questions (Likert scale). Qualitative – open ended comments; reflective journaling.	All 13 items were rated as strongly agree or somewhat agree by more than 75% of students; 61% strongly agreed that they felt more confident and were able to recognise changes in the patient's condition; 62% strongly agreed that they learned as much from observing as if they were actively involved; 65% strongly agreed that the programme was a valuable learning tool. Mean scores of 4.5 or greater were achieved in each outcome indicated that students were very satisfied with the learning experience and could apply concepts to clinical practice. Themes – symptom management; teaching the patient and family; listening closely; shared goals; respect wishes and opinions; power of presence and kindness; appreciation of different beliefs; death as part of living; appreciation for end of life care; less fear and more confidence in caring for a dying person; providing comfort through compassionate interventions; being an advocate; collaborating and better understanding of IDT roles; awareness of ethical issues.
Pullen et al. (2012) USA	Not research	2006–2010: n = 90 students (2nd year advanced medical surgical course in the ADN programme), 2011 – 140 nurses and 25 allied health students (not specified).	2 day programme – Day 1 – Introduction: Preparation for simulation, IDT meeting, and patient interview. Day 2 – Patient interview (standardised patient); Concurrent IDT meetings: Simulation: final moments of life – high fidelity simulation and wife played by faculty, groups of 4–5 students at 5 concurrent stations, role-played nurse or an IDT member. Debriefing following simulation.	Not research	Evaluation of 7 learning outcomes (Likert scale).	Mean scores of 4.5 or greater were achieved in each outcome indicated that students were very satisfied with the learning experience and could apply concepts to clinical practice. Themes – symptom management; teaching the patient and family; listening closely; shared goals; respect wishes and opinions; power of presence and kindness; appreciation of different beliefs; death as part of living; appreciation for end of life care; less fear and more confidence in caring for a dying person; providing comfort through compassionate interventions; being an advocate; collaborating and better understanding of IDT roles; awareness of ethical issues.
Gillan et al. (in press-3) Australia	Not research	N = 120 3rd year students (enrolled in compulsory aged care and palliative care units). During 5 day residential school, groups of 20–25 participated in simulation.	Doris – 89 year old lady with Metastatic bowel cancer. End of life care during dying scene. Groups of 4 students role-played daughter, granddaughter/son, RN and SN. Remainder participated as observers. Debriefing and Evaluation – video replayed and facilitated discussion.	Not research	Thematic analysis of student evaluations (voluntary and anonymous); 2 Likert scale questions and 5 open ended questions.	Themes: 1) linking theory to practice; 2) approaching families of dying patients; 3) an encounter with death; 4) hands on experience in a protected environment; 5) importance of post simulation debriefing

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Nevertheless, in conducting simulation debriefing Smith-Stoner (2009a) advises that debriefing must be “tightly controlled” by focusing specifically on course and simulation objectives and allowing participants and observers to share feelings and emotions only in the closing moments of the debriefing as students tend to stray from simulation objectives. The author also suggests that the facilitator must redirect students to focus on clinical reasoning and learning rather than on trivial issues such as mistakes made during simulation.

Leighton (2009) also recommends that the facilitator must establish a safe, non-judgemental environment where participants feel free to confidentially share thoughts and feelings.

One emanating theme highlighted in debriefing, is ‘debriefing’. Debriefing involves the process of facilitating “open expression and reflection of emotions related to distress over loss” (Hamilton, 2010, p. e134). Provided by a supportive facilitator, debriefing allows students with “emotion-focussed responses” an opportunity to discuss concerns and facilitate exploration and expression of feelings related to the sensitive issues of grief and end of life care (Hamilton, 2010).

Methodological Issues Raised from Studies

In quantitative and mixed method studies, it is important to note methodological issues related to sample size and tools used to measure outcomes. For quantitative studies, the sample size was limited to 79 3rd year students in Swenty and Eggleston’s (2011) study, although, in Fluharty et al.’s (2012) study 370 senior nursing students participated in their quasi-experimental multi-site study. The sample size was also limited in the mixed method studies, Moreland et al.’s (2012) study involved 14 junior nursing students, while Twigg and Lynn (2012) used similar numbers for their pilot study (n = 16).

It is notable that some tools used to evaluate change in knowledge acquisition, communication skills, self-confidence, and student satisfaction are validated. Instruments used to evaluate knowledge acquisition have had content or face validity established, for example the “Knowledge related to end of life care instrument” (Fluharty et al., 2012); and the NCLEX style exam (Twigg and Lynn, 2012). The quasi-experimental multi-site study undertaken by Fluharty et al. (2012) used a validated assessment tool “The End of Life Communication Assessment tool” to examine the students’ communication skills in working with end of life patients after the simulation. However a Cronbach’s Alpha co-efficient of 0.7, indicates acceptable but stands at the end of a low degree of reliability.

Another issue noted is that the positive effects of simulation rely on self-report. In Fluharty et al.’s (2012) study, self reported communication scores were ranked as high reflecting the participant’s perception that they had learned to communicate in this setting (Fluharty et al., 2012). Fluharty et al. (2012) also reported an increase in student self-confidence in caring for a dying patient following simulation. Although this study used a reliable instrument, one of the limitations of the study is again the self-reporting nature of this scale. Furthermore, given that students’ perceptions were measured only on post-simulation, rather than pre and post, it is difficult to determine if the change was an effect of the simulation.

Discussion

A review of literature on end of life care education suggests that undergraduate nursing students are not adequately prepared for end of life care (Gillan et al., in press-b). A number of innovative approaches to improve this situation have been reviewed and discussed in part one of this paper (Gillan et al., in press-b). End of life care education in undergraduate nursing programmes has reached a new era with the introduction of simulation. The available literature on simulation in end of life care education has been reviewed critically, and the following points have implications for implementation and warrant further discussion.

Psychological Safety of Participants

One of the major challenges highlighted in the literature on end of life simulation is ensuring the psychological safety of the participants. In promoting psychological safety of participants, 4 key elements are highlighted in the literature reviewed. 1) Pre-briefing: pre-briefing may include preparation activities and should include informing students of the nature of the simulation (Sperlazza and Cangelosi, 2009), and that the simulator may or will die (Leighton, 2009); 2) Debriefing: debriefing is important in the learning process of simulation as it allows students to explore feelings about the events that transpired during the simulation (Leighton, 2009); 3) Degriefing: degriefing is highlighted as important in promoting the psychological safety of participants and allows students to explore and express feelings related to fears and grief (Hamilton, 2010); 4) Stress and anxiety: although many papers report on the benefits of end of life care simulation, the findings by Twigg and Lynn (2012) suggest that simulation may cause stress and anxiety. Although only a small sample size (n = 16) was used in this instance, comparison of Concerns About Dying scores revealed that a simulation approach for end of life care increased stress and anxiety in some nursing students. The authors acknowledge that the stress may be a result of no previous exposure to this content in the undergraduate programme and that students were in their final semester of nursing and about to enter the nursing profession as RN’s within 6 months. The reality of the simulation may have helped students recognise the inherent stress in caring for a dying person. Regardless of this consideration, educators must be aware that end of life care simulation may have this undesired effect on some students and must take the necessary steps to provide support to these students, such as those already outlined in this discussion.

Barriers and Limitations of End of Life Care Simulation

Although this teaching strategy is described as innovative, and despite not being addressed in any of the literature described in this review, the barrier of financial cost is an important consideration.

First of all, financial costs of initial purchase, ongoing maintenance and equipment upgrade can be considerable (Jansen et al., 2009). Cost factors also include the cost of running the simulators, and training staff members in the use, upkeep and repair of simulation equipment (Rothgeb, 2008). Rapid advances in technology also means simulators must also be regularly upgraded further adding to the financial cost (Feingold et al., 2004).

Not only is cost an important factor but also a lack of qualified and adequately trained nursing academics to teach end of life care simulation is a further important consideration. High fidelity manikins that involve programming and running of clinical scenarios requires a high level of training and expertise. The amount of time required for facilitators to become skilled in simulation and to develop scenarios also needs to be considered. This is important since the greatest barrier to the use of simulation in the nursing curricula is considered to be the complexity and time required to implement and utilise this equipment (Gillan et al., in press-a). Alternatively, using standardised patients also requires considerable knowledge and expertise and additional resources such as individuals to role-play team or family members are often required (Rothgeb, 2008).

A considerable limitation of simulating death is the physical limitations of the technology, for example manikins do not have the ability to change skin colour or temperature (Smith-Stoner, 2009b), display non-verbal communication (Lasater, 2007), or mimic advanced changes in respiratory patterns (Tuxbury et al., 2012). Realistic scenarios used have some effect to compensate this limitation but further study is required to establish knowledge and evidence on how to develop realistic scenarios, what it involves, and what students’ personal experience will be.

Limitations of Literature Review

Although the search strategy included a number of search terms and databases, the search may not have identified all the relevant literature on this topic. Since the review was restricted to published literature only, literature that has not been published may not have been identified. The review was not restricted to English only publications, however, papers of relevance that were not in English may not have been identified in the search strategies. Nevertheless, this paper aims to be a comprehensive but not exclusive review of the current available research on end of life care simulation.

Conclusion and Recommendations

The findings of the studies reviewed support end of life care simulation as a strong and viable pedagogical approach to learning for a number of reasons which include an increase in knowledge acquisition, improved communication skills, improved self confidence, an increased student satisfaction and level of engagement in learning. The inclusion of family members in end of life simulation is important to promote therapeutic communication, holistic care, and supporting family in the grief process. One of the benefits of end of life care simulation in qualitative studies was 'experiential learning' which facilitated students to 'link theory to practice'. Self-confidence and self-efficacy were the notable outcomes of quantitative studies. However, none of these are clinically tested and measured. Given that the psychological safety of students is essential and the cost involved in end of life care simulation can be significant, the implementation of end of life care simulation as a teaching strategy warrants careful consideration.

Research on the use of simulation in nursing is still in its infancy. Furthermore, there is a paucity of research and literature particularly on end of life care simulation with literature principally emanating from the USA. The gaps in the literature are, firstly, the limited research on end of life care simulation with only six research papers identified from the literature search. This highlights the need for further research using various research designs to adequately explore the issues surrounding end of life care simulation. The use of qualitative research is a particularly important means of exploring in depth students' experiences with end of life care simulation. There are currently only two qualitative research articles, one using a phenomenological approach that seeks to understand nursing students' experiences with end of life simulation and the other using focus group methods.

Secondly, the necessity to design and conduct research using measurable outcomes to test pedagogical methods and to establish reliability and validity of current tools used has been highlighted. Lastly, follow-up studies are required to investigate if students who have exposure to end of life care simulation during their undergraduate programme have made any changes in patient outcomes and nursing practice.

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7.3 Appendix C: Doris Scenario Background

Medical History: 89 year old Doris was diagnosed with unresectable Dukes C Bowel Cancer with advanced Liver and Lung Metastases 3 months ago following a history of weight loss, nausea, vomiting, rectal bleeding, and irregular bowel habits including constipation. Doris originally underwent a regime of oral Chemotherapy (Xeloda), but ceased after 4 weeks due to severe side effects and effect on quality of life.

Co-morbidities: Cataract extraction 2 years ago, GORD, Angina.

Social history: Doris' husband Damien died from heart failure 5 years ago. Doris lives alone but her daughter Dana and son Darren both live close by. Doris also has a young grandson, David who is studying Engineering at the local University.

Doris also has many friends from her craft and Bowling groups. Prior to Doris's diagnosis of Bowel cancer, Doris led an active social life.

Medications: MSContin 40mgs BD, Ordine liquid 5mgs/ml 2mls PRN, Maxalon 10mgs QID, Dexamethasone 4mgs Daily. Anginine Sublingual PRN, Coloxyl with Senna 2 nocte PRN, Paracetamol 500mgs x2 QID.

Disease Progression: Doris was admitted to hospital one week ago with a bowel obstruction and dehydration. Doris was initially treated with a nasogastric (NG) tube and intravenous therapy (IV) resulting in effective treatment of bowel obstruction. After careful discussion with Doris and her family the treating doctor has advised against further treatment and Doris and her family have agreed for Palliation. The doctor has discussed nor for resuscitation (NFR) orders, consent has been given and NFR is clearly documented in Doris's notes and care plan. The NG tube and IV therapy have been removed and Doris has been discharged home from hospital.

Several days have passed and Doris has been experiencing pain at home. She has now been admitted to the local hospital for review and management of pain and other symptoms.

7.4 Appendix D: University of Newcastle Human Research Ethics Committee (HREC) Notification of Expedited Approval

HUMAN RESEARCH ETHICS COMMITTEE



Notification of Expedited Approval

To Chief Investigator or Project Supervisor:	Associate Professor Pamela Van Der Riet
Cc Co-investigators / Research Students:	Mrs Pauline Gillan Doctor Sarah Jeong
Re Protocol:	The Experience of Undergraduate Nursing Students with End of Life care Simulation
Date:	09-May-2012
Reference No:	H-2012-0059
Date of Initial Approval:	09-May-2012

Thank you for your **Response to Conditional Approval** submission to the Human Research Ethics Committee (HREC) seeking approval in relation to the above protocol.

Your submission was considered under **Expedited** review by the Chair/Deputy Chair.

I am pleased to advise that the decision on your submission is **Approved** effective **09-May-2012**.

In approving this protocol, the Human Research Ethics Committee (HREC) is of the opinion that the project complies with the provisions contained in the National Statement on Ethical Conduct in Human Research, 2007, and the requirements within this University relating to human research.

Approval will remain valid subject to the submission, and satisfactory assessment, of annual progress reports. *If the approval of an External HREC has been "noted" the approval period is as determined by that HREC.*

The full Committee will be asked to ratify this decision at its next scheduled meeting. A formal *Certificate of Approval* will be available upon request. Your approval number is **H-2012-0059**.

If the research requires the use of an Information Statement, ensure this number is inserted at the relevant point in the Complaints paragraph prior to distribution to potential participants You may then proceed with the research.

Conditions of Approval

This approval has been granted subject to you complying with the requirements for *Monitoring of Progress, Reporting of Adverse Events, and Variations to the Approved Protocol* as detailed below.

PLEASE NOTE:

In the case where the HREC has "noted" the approval of an External HREC, progress reports and reports of adverse events are to be submitted to the External HREC only. In the case of Variations to the approved protocol, or a Renewal of approval, you will apply to the External HREC for approval in the first instance and then Register that approval with the University's HREC.

- **Monitoring of Progress**

Other than above, the University is obliged to monitor the progress of research projects involving human participants to ensure that they are conducted according to the protocol as approved by the HREC. A progress report is required on an annual basis. Continuation of your HREC approval for this project is conditional upon receipt, and satisfactory assessment, of annual progress reports. You will be advised when a report is due.

- **Reporting of Adverse Events**

1. It is the responsibility of the person **first named on this Approval Advice** to report adverse events.
2. Adverse events, however minor, must be recorded by the investigator as observed by the investigator or as volunteered by a participant in the research. Full details are to be documented, whether or not the investigator, or his/her deputies, consider the

- event to be related to the research substance or procedure.
3. Serious or unforeseen adverse events that occur during the research or within six (6) months of completion of the research, must be reported by the person first named on the Approval Advice to the (HREC) by way of the Adverse Event Report form within 72 hours of the occurrence of the event or the investigator receiving advice of the event.
 4. Serious adverse events are defined as:
 - Causing death, life threatening or serious disability.
 - Causing or prolonging hospitalisation.
 - Overdoses, cancers, congenital abnormalities, tissue damage, whether or not they are judged to be caused by the investigational agent or procedure.
 - Causing psycho-social and/or financial harm. This covers everything from perceived invasion of privacy, breach of confidentiality, or the diminution of social reputation, to the creation of psychological fears and trauma.
 - Any other event which might affect the continued ethical acceptability of the project.
 5. Reports of adverse events must include:
 - Participant's study identification number;
 - date of birth;
 - date of entry into the study;
 - treatment arm (if applicable);
 - date of event;
 - details of event;
 - the investigator's opinion as to whether the event is related to the research procedures; and
 - action taken in response to the event.
 6. Adverse events which do not fall within the definition of serious or unexpected, including those reported from other sites involved in the research, are to be reported in detail at the time of the annual progress report to the HREC.

• ***Variations to approved protocol***

If you wish to change, or deviate from, the approved protocol, you will need to submit an *Application for Variation to Approved Human Research*. Variations may include, but are not limited to, changes or additions to investigators, study design, study population, number of participants, methods of recruitment, or participant information/consent documentation. **Variations must be approved by the (HREC) before they are implemented** except when Registering an approval of a variation from an external HREC which has been designated the lead HREC, in which case you may proceed as soon as you receive an acknowledgement of your Registration.

Linkage of ethics approval to a new Grant

HREC approvals cannot be assigned to a new grant or award (ie those that were not identified on the application for ethics approval) without confirmation of the approval from the Human Research Ethics Officer on behalf of the HREC.

Best wishes for a successful project.

Professor Allyson Holbrook
Chair, Human Research Ethics Committee

For communications and enquiries:
Human Research Ethics Administration

Research Services
 Research Integrity Unit
 HA148, Hunter Building
 The University of Newcastle
 Callaghan NSW 2308
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Human-Ethics@newcastle.edu.au

Linked University of Newcastle administered funding:

Funding body	Funding project title	First named investigator	Grant Ref
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7.5 Appendix E: University of New England Ratification of HREC Expedited Approval

Jo-Ann Sozou

From: Jo-Ann Sozou
Sent: Tuesday, 31 July 2012 9:30 AM
To: 'pamela.vanderriet@newcastle.edu.au'; 'sarah.jeong@newcastle.edu.au'; Pauline Gillan
Subject: HREC Ratification Approval - July 2012 - E2 - van der Riet, Jeong & Gillan

Dear A/Prof van der Riet, Dr Jeong & Ms Gillan

Thank you for your response to the conditions set down by the Human Research Ethics Committee (HREC). Your response satisfactorily addresses the concerns and questions raised by the Committee.

We are now pleased to approve the ratification of your research project entitled, "The Experience of Undergraduate Nursing Students with End of Life care Simulation."

If you have any queries about your ethics clearance, or require any assistance in the future, please do not hesitate to contact me by email, or on 02 6773 3449. My office is in the Research Services Office which is located on the top floor of the T.C Lamble Building.

Regards

Jo

Mrs Jo-Ann Sozou
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7.6 Appendix F: Letter of Invitation to Participate in Research Project



Pauline Gillan (PhD Candidate)
P.O.Box U90
University of New England
Armidale
NSW 2351
T: (02) 6773 2532
F: (02) 6773 3666

Email: c3081621@uon.edu.au
February 18th 2013

Letter of Invitation to participate in Research Project: "The Experiences of Undergraduate Nursing Students with End of Life Care Simulation"

Dear Student,

I am a lecturer at the University of New England, teaching into the Bachelor of Nursing program. I am also a registered nurse with extensive experience in palliative care nursing. My experience in palliative care spans several years as a Specialist Community Palliative Care Nurse. In my experience and through my extensive research into the topic of end of life, it is widely known that providing end of life care is a challenging and anxiety provoking prospect for many undergraduate nursing students. International and Australian research undeniably indicates that undergraduate nursing students are largely unprepared to provide competent and quality end of life care.

Because of challenges in nursing education due to the limited availability of clinical placements for students, nursing educators at the UNE are now utilising simulation on end of life care in an attempt to provide quality learning experiences with end of life care. Although there have been attempts to prepare nursing students to provide competent and compassionate end of life care, to date, there are few examples of simulation being used to prepare undergraduate nursing students for end of life care.

As part of my PhD studies with the University of Newcastle, I am conducting a study that explores the experiences of 3rd year undergraduate nursing students with end of life care simulation.

I am interested in exploring your experiences with end of life care simulation and with clinical experiences with end of life care. During intensive residential school for HSNS301 and HSNS314 you will participate in end of life care simulation sessions as a teaching and learning tool. The study will involve participant observation by me as the researcher, during a post simulation debriefing session. A final requirement for the study will involve an interview of approximately 40-60 minutes duration, at the end of your third year of the undergraduate nursing program following all clinical placements for third year.

On the following pages you will find a Participant Information Sheet outlining the research project (for you to keep) and what it will mean for you to participate. I would be most appreciative if you would take a few minutes to read the information attached. If you are interested in participating in this study please return the enclosed Consent Form to me by email on c3081621@uon.edu.au or by mail at the address below.

I have obtained ethical approval from the University of Newcastle Human Research Ethics Committee and the University of New England Human Research Ethics Committee to undertake this study.

Thank you for taking the time to read this letter and for considering my invitation to participate in this study, I look forward to hearing from you in the near future.

Yours Sincerely,

Pauline Gillan (PhD Candidate),
P. O. Box U90,
UNE, NSW 2351
Telephone: (02) 6773 2532
Email: c3081621@uon.edu.au

7.7 Appendix G: Participant Information Statement for Research Project



Dr Pamela van der Riet
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Information Statement for the Research Project:

"The Experience of Undergraduate Nursing Students with End of Life Care Simulation"

Document Version 1; dated 15/2/12

You are invited to participate in the research project identified above which is being conducted by the PhD Candidate Pauline Gillan from the School of Nursing and Midwifery, Faculty of Health, University of Newcastle; Assoc Prof Pamela van der Riet, from the School of Nursing and Midwifery, Faculty of Health, University of Newcastle; and Dr Sarah Jeong, from the School of Nursing and Midwifery, Faculty of Health, University of Newcastle.

Why is the research being done?

Providing end of life care is a challenging and anxiety provoking prospect for many undergraduate nursing students. International and Australian research undeniably indicates that undergraduate nursing students are largely unprepared to provide competent and quality end of life care. There have been attempts to prepare nursing students to provide competent and compassionate end of life care. However, to date, there are few examples of simulation being used to prepare undergraduate nursing students for end of life care. The purpose of the research is to study the experiences of 3rd year undergraduate nursing students with end of life care simulation.

The aims of the study are to:

- 1) Explore the experiences of students with end of life care simulation
- 2) Investigate the impact of simulation on student's clinical practice of end of life care

Who can participate in the research?

Student nurses who are currently enrolled in the Bachelor of Nursing Program undertaking the compulsory units of study of HSNS301 and HSNS314 at the University of New England.

Who can NOT participate in the research?

Student nurses who feel they have unresolved issues of grief should not participate in this study.

Student nurses who are not culturally comfortable or for whom it is against their culture to talk about death and dying should not participate in this study.

What choice do you have?

Participation in this research is entirely your choice. Only those people who give their informed consent will be included in the project. Whether or not you decide to participate, your decision will not disadvantage you. Although the student researcher is also teaching into the compulsory units of study (HSNS301 and HSNS314), your decision to participate or not participate in this research will have no impact on your relationship with the researcher or your academic assessment and progression. The

student researcher is not the unit co-ordinator for these units and has no responsibility or authority for allocating marks for the students participating in the research.

If you do decide to participate, you have the right to withdraw from the project at any time without giving any reason and with no impact upon your studies. If you feel uncomfortable during the interview it will be stopped.

What would you be asked to do?

If you agree to participate, you will be asked to:

- Read this study information letter;
- Complete your name and contact details, sign and return the consent form to the researcher Pauline Gillan (PhD candidate) by email or mail ;
- Participate in end of life care simulation and being videotaped as a requirement for standard teaching practice in this course;
- Participate in a debriefing session, being observed by the researcher and being audio taped. This is additional to standard teaching practice in this course and required for research participation
- Give permission for an interview to be recorded onto audio tape and transcribed and participate in an interview about your experiences with end of life care simulation.
- Bring an item of meaning to the interview
- Review your transcribed interview and make changes that you feel are necessary to clarify your statements if required.

Topics to be discussed during the interview will include the following:

- Experiences with end of life care simulation;
- Clinical experiences with providing end of life care during clinical placement;
- Attitudes towards death and dying.

How much time will it take?

Participating in end of life care simulation and a debriefing session do not require any addition to your personal time as participating in the end of life care simulation and debriefing sessions is a requirement for completion of the units HSNS301 and HSNS314.

Interviews will be scheduled at a mutually convenient time for you the participant and the researcher and will take place following the final clinical placements for the 3rd year of the Bachelor of Nursing program at around October or November 2013 and into the early part of 2014 if required.

It is anticipated that the interview should take about 40-60 minutes.

What are the risks and benefits of participating?

There is unlikely to be any immediate or direct risks or benefits to participants, however, it is believed that participation in interviews can be therapeutic. It is hoped that future nursing students, nurses and patients will benefit from new knowledge that this study will generate. Should you become distressed during the interview, the tape will be stopped and emotional support will be available by a counsellor. A counsellor from the University of New England will be prearranged. This counsellor is a support provider who is independent of the research.

Interview questions asked during this research will be related to experiences with death and dying. In some instances participants may experience feelings of sadness related to a recent death of some-one close to them. Please advise the researcher if there may be any recent issues related to issues of grief. Participants are also reminded that you should reconsider participation in this research if you have had a recent or any unresolved issues of grief. In some instances the interview process may provide a therapeutic outlet to the issue of grief and some participants might find this process is helpful in the grieving process. Nevertheless, participants are requested to divulge any potentially distressing issues related to grief and will be provided with support by experienced counsellors provided by the University of New England.

Contact details for the University of New England Counsellor are by phone on 6773 2897 or via email on conselling.service@une.edu.au

How will your privacy be protected?

The researcher will transcribe the interview data or employ a professional transcriber. Any information collected by the researcher which might identify you will be stored securely and only accessed by the researcher unless you consent otherwise, except as required by law. Data will be retained for at least 5 years at the University of Newcastle. Pseudonyms will be used in publications or conference presentations derived from the research. On completion of the data collection all data will be kept in a secure password protected directory for five years. After which, all identifying information and data will be destroyed following University of Newcastle procedures for shredding of sensitive documents.

Audio tapes and visual images obtained during the research will be stored as a single electronic copy on the researcher's laptop computer and password protected. All audio and visual data collected will be destroyed after 5 years as specified above.

All participants will be de-identified using pseudonyms throughout the research process. Although the researcher will endeavour to protect your identity as a participant, there is always the potential that information can be identified.

How will the information collected be used?

This research will be submitted as a Thesis for Doctorate Candidature. Results from this study may be submitted for publication in refereed journals or presented at conferences. Pseudonyms will be used in publications derived from the research. Individual participants will not be identified in any reports arising from the project.

If requested you will be able to review the transcription of audio tapes, video tapes and interviews to edit your contribution. The transcription will be available to you during Trimester 2 or 3 2014. A copy of the summary of the findings of the study will be available within four years and will be sent to you upon request. Please contact the researchers by e-mail, phone or mail to request the summary of findings.

What do you need to do to participate?

Please read this Information Statement and be sure you understand its contents before you consent to participate. If there is anything you do not understand, or you have questions, firstly contact the primary researcher, Pauline Gillan (PhD Candidate), or secondly research supervisors Assoc Prof Pamela van der Riet, or Dr Sarah Jeong.

If you would like to participate, please complete the attached Consent Form and return it to the primary researcher, Pauline Gillan (PhD Candidate) by:

- Emailing the signed Consent form to Pauline Gillan at c3081621@uon.edu.au, or returning by post addressed to Pauline Gillan at the address below.

Further information

If you would like further information please ask Pauline Gillan (PhD Candidate) in the first instance, otherwise contact Assoc Prof Pamela van der Riet, or Dr Sarah Jeong.

Whatever your decision about participating in this study, I thank you for taking the time to read this information sheet and for considering this invitation.

Assoc Prof Pamela van der Riet,
PhD Supervisor,
Telephone: (02) 49216261
Fax: (02) 4921 6301
Email: Pamela.vanderriet@newcastle.edu.au
Address: School of Nursing and Midwifery,
Faculty of Health,
University of Newcastle,
University Dr,
Callaghan,

NSW 2308.

Dr Sarah Jeong,
PhD Supervisor,
Telephone: (02) 4349 4535
Fax: (02) 4348 4035
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Address: University of Newcastle,
P. O. Box 127,
Ourimbah,
NSW 2258.

Pauline Gillan,
PhD Candidate.
Telephone: (02) 6773 2532
Fax: (02) 6773 3666

Email: c3081621@uon.edu.au
Address: P.O. Box U90,
University of New England,
NSW 2351.

Complaints about this research

This project has been approved by the University's Human Research Ethics Committee, Approval No. (H-2012-0059)

Should you have concerns about your rights as a participant in this research, or you have a complaint about the manner in which the research is conducted, it may be given to the researcher, or, if an independent person is preferred, to the Human Research Ethics Officer, Research Office, The Chancellery, The University of Newcastle, University Drive, Callaghan NSW 2308, Australia, telephone (02) 49216333, email Human-Ethics@newcastle.edu.au.

7.8 Appendix H: Research Consent Form

Consent Form



Assoc Prof Pamela van der Riet
School of Nursing and Midwifery
Faculty of Health
University of Newcastle
University Dr
Callaghan Campus
Callaghan,
NSW
T+61249216261
F+61249216301

Pamela.vanderriet@[newcastle.edu.au](mailto:pamela.vanderriet@newcastle.edu.au)

Consent Form for the Research Project:

The Experience of Undergraduate Nursing Students with End of Life Care Simulation

Pauline Gillan (PhD candidate)
Assoc Prof Pamela van der Riet,
Dr Sarah Jeong,

Document Version 2; dated 30/4/12

You are invited to participate in the research project identified above which is being conducted by Pauline Gillan from the School of Nursing and Midwifery, Faculty of Health, University of Newcastle; Assoc Prof Pamela van der Riet, from the School of Nursing and Midwifery, Faculty of Health, University of Newcastle; and Dr Sarah Jeong, from the School of Nursing and Midwifery, Faculty of Health, University of Newcastle.

I agree to participate in the above research project and give my consent freely.

I understand that the project will be conducted as described in the Information Statement, a copy of which I have retained.

I understand I can withdraw from the project at any time and do not have to give any reason for withdrawing.

I understand that I may review and edit the transcript.

- I am aware that I have the right to review and edit the transcript of my interview
- If I choose to review and edit the transcript I will contact the primary researcher to arrange this

I understand that potentially identifying material will be used in this research.

I consent to:

- Being audio recorded and observed by one or more of the research team while attending a compulsory end of life care simulation debriefing session; Yes/No
- Participating in an interview and having it audio recorded; Yes/No
- Bringing an item of meaning to the interview Yes/No

I have had the opportunity to have questions answered to my satisfaction.

Print Name: _____
Contact Details: _____
Signature: _____ **Date:** _____

7.9 Appendix I: Reminder Letter



Pauline Gillan (PhD Candidate)
P.O.Box U90
University of New England
Armidale
NSW 2351
T: (02) 6773 2532
F: (02) 6773 3666

Email: pgillan3@une.edu.au
February 2nd 2012

Research Project: “The Experiences of Undergraduate Nursing Students with End of Life Care Simulation”

Dear Participant,

I am a lecturer at the University of New England, teaching into the Bachelor of Nursing program. As part of my PhD studies with the University of Newcastle, I am conducting a study that explores the experiences of 3rd year undergraduate nursing students with end of life care simulation.

I recently sent you a letter of invitation, an Information Statement, and a Consent Form to participate in a research project exploring the experiences of undergraduate nursing students with end of life care simulation. This letter is to remind you of the invitation to participate in this research project.

If you have signed and returned the participant consent form, I'd like to take this opportunity to thank you for your participation.

If you are willing to participate in this research and have not yet returned the consent form, please sign the attached consent form and return this by email or by post.

For those who do not wish to participate in this study, please disregard this letter.

Thank you for taking the time to read this letter and for further considering my invitation to participate in this study, I look forward to hearing from you in the near future.

Yours Sincerely,

Pauline Gillan
PhD Candidate,
P. O. Box U90,
UNE,
NSW 2351
Telephone: (02) 6773 2532
Email: pgillan3@une.edu.au

7.10 Appendix J: Demographics of Participants

Demographic	
Age	20–51 years
Sex	Female n=13 (72%) Male n=5 (28%)
Cultural background	Australian n=15 (English/Irish X1; Polish/Ukraine X1) International n=1
Enrolment	F/T n=13 (72%) P/T n= 5 (28%)
Years of nursing experience	0–27 years
Nursing qualification	EN n=9 (50%) AIN n=6 (33%) None n=3 (17%)

7.11 Appendix K: Participant Interview Schedule

Research Topic: “The Experience of Undergraduate Nursing Students with End of Life Care Simulation”

Each interview should take up to one hour. The following are what the researcher intends to extrapolate from the data sets. However, these questions to participants are a guide only. They will not necessarily be asked in strict sequence but rather act as prompts in an open-ended interview process.

Name of Participant (Pseudonym):

Date:

Postcode of Clinical Placement/s:

(Note: Ask if participant has any questions before starting the interview. Check participant has signed the consent form.)

Reassure participant that confidentiality and privacy will be maintained with the use of pseudonyms in publications or conference presentations.

1) Post Simulation Semi-structured Interview Questions:

Remind students of the simulation experience by giving a brief outline of the Doris scenarios.

2) Questions related to Simulation experience:

- I. What were your experiences with the end of life care simulation?
- II. Could you describe your feelings in relation to undertaking end of life simulation? How did you feel going into the simulation session?

3) Questions related to End of life care experiences before the simulation:

- I. Did this simulation scenario bring back any memories of previous episodes of end of life care that you experienced before the simulation?
- II. Can you tell me about this/these experiences?
- III. Was this the first experience you have had with caring for someone who was dying?
(if not first experience, move on to VI).
- IV. If this was your first end of life care experience, what was your expectation of this first end of life experience following the simulation experience?
- V. How did you perceive your first experience and did this experience meet your expectations, if so how? If not why not?
- VI. What were the emotions you experienced during this first experience? (e.g. fear, despair etc).

4) Questions related to recent End of life care clinical experiences:

- I. Have you had any recent clinical experience with providing end of life care following undertaking the end of life care simulation (from 1st trimester this year)?
(If no experiences, move on to next section and ask about communication)
- II. Could you tell me about this/these experiences?
- III. What was your role in providing this care?
- IV. How did this experience make you feel?

- V. Was there anything negative about this experience?
- VI. Could you think of something positive about this experience?
- VII. In retrospect did this clinical experience align or correlate with the simulation scenario/experience?

5) Questions related to simulation and preparation for End of life care:

I. Do you think undertaking the end of life simulation session has helped prepare you to undertake this care? If so how? OR What effect do you think this simulation session had on your preparation to undertake end of life care to a dying patient?

II. Do you think this simulation session has had any effect on improving your communication skills in dealing with death and dying for bereaved loved ones and patients? OR Do you think you are now more able to communicate more effectively with the patient and their loved ones?

Could you give some examples?

6) Questions related to personal experiences with death and dying:

I. Did the simulation scenario bring back any personal experiences of death and dying?

II. Do you want to tell me about that or these experience/s?

III. Have you experienced any feelings brought about from any clinical experience/s with end of life care that you may reflected your own personal experience with death and dying?

IV. How did you make sense of these feelings? (reconcile)

With conclusion of interview, ending with the item, this may bring up some emotion and allow this to be discussed in full without the pressure of moving on to continue the interview, allowing participants to fully express the meaning of this item that they have chosen.

I. Have you brought an item with you that is meaningful to you in relation to end of life care and death and dying?

II. Could you tell me why this is meaningful to you?

III. Could you tell me about the context of this image/item/object? OR describe this item

Concluding questions and remarks: Just before we finish, I would just like to ask a couple of questions about undertaking this research:

1. Could you tell me what motivated you to undertake this research?

2. Having participated in this research, was this what you expected?

Is there anything else you would like to add about this experience, both of the simulation and the research experience?

7.12 Appendix L: Table of Threads Decision Trail

Quote	1	2	3	4	Final Thread
<p>Holly: “I liked the way that they [the nurses] looked after him ... and they were really amazing with the family and ... just really respectful ... which is beautiful... it ended up being a good death (p. 8) ... [the nurses] cried with the family (p.9) ... [were] really empathetic and ... compassionate and shared that emotion with them ... and they [the nurses] were really respectful with the body after death as well ... even talking to him ... and just keeping his dignity when they were washing him (p. 10) ... I see by being by someone’s bedside as they’re passing away just as much of a privilege as being there at the birth ... death can be a really beautiful thing (p. 18) ..., I just thought “Oh, that is really beautiful ...”. (p. 19)</p>	<p>It was just beautiful/death seen as beautiful/ Death as beautiful, and a privilege</p>	<p>Being at someone’s bedside at death a privilege, death can be beautiful</p>	<p>(Thread 1) *The role of others in making death experiences positive (beautiful versus difficult)</p>	<p>(Thread 1) *The role of others in defining death experiences (beautiful versus ugly)</p>	<p>(Thread 1) *The role of others in shaping death experiences</p>
<p>Holly: “Doris, it’s Holly here, I’m the nurse on the shift today, just going to have a look how you’re going” (End of life scene p. 2) ... “so, what’s happening now is that she’s [Doris – manikin] ... just taking her last breaths now” ... “We will just leave you [family members, David and Grace] with this time to say goodbye to her ... I encourage you to hold her and just talk to her”. (p. 4)</p>	<p>Family presence at the end of life (in simulation and in clinical practice)</p>	<p>Managing self amidst presence of family</p>	<p>(Thread 2) *Managing self amidst family</p>	<p>(Thread 2) *Attending to family centred care</p>	<p>(Thread 2) *Attending to family at the end of life</p>

<p>James: “We asked him [family member] how he was first because he looked like he was worried so we asked if you were ok first ... It wasn’t just about her [dying person] ... It was about him [her family] as well”. (p. 17, Debriefing)</p>					
<p>Holly: “They are really frequent things that you see ... and I felt more confident ... more educated by the end ... using the simulation to put all of the theory into practice is really good”. (p. 3)</p> <p>Luke: “Since then [the simulation] I’ve had conversations with elderly patients, and that sort of thing has come up, end of life decisions ... that definitely helped me with my communication...at that stage... (p. 10) ... [the simulation] highlighted the responses that you might have when speaking with the family ... that helps a lot when family are asking ‘what’s going on?’”. (p. 15)</p>	<p>Learning from others in simulation/ Lessons learned in simulation/ theory into practice</p>	<p>Interweaving simulation and clinical experiences/ theory into practice</p>	<p>(Thread 3) *Theory and practice become one (synergised/ symbiotic)</p>	<p>(Thread 3) *Theory and practice become one- synergised</p>	<p>(Thread 3) *Theory, practice and experience become synergised</p>
<p>Luke: “In my gap year, my best friend’s sister suicided and... the hardest thing was ... all of a sudden you can’t talk because you just don’t know what to say ... I just remember, just completely shutting off and thinking ‘what can you say?’”. (p. 19)</p> <p>Louise: “She was asking if she was going to die ... I didn’t know how to answer that ...I was a bit taken aback ... bit surprised ... I just went blank ... no idea what to say.” (pp. 6–7)</p>	<p>What do you say? Being in the midst of difficult conversations</p>	<p>Managing self amidst uncertainty (difficult conversations)</p>	<p>(Thread 4) *Managing self amidst difficult conversations and uncertainty</p>	<p>(Thread 4) *Managing self amidst difficult conversations</p>	<p>(Thread 4) *Managing self amidst negotiating difficult conversations at the end of life</p>
<p>Louise: “The dying phase was very confronting ... I have seen dead bodies, ... after they have died ... but I have never actually witnessed</p>	<p>First death experience, not witnessing</p>	<p>Managing self in the midst of</p>	<p>(Thread 5) *Managing self amidst after</p>	<p>(Thread 5)</p>	<p>(Thread 5) *Managing self amidst an</p>

<p>someone die (p. 3) ... it was scary ... I've experienced the cleaning of the bodies ... but ... not being here," (p. 5, Dying scene)</p> <p>Sarah: "To this day, I remember ... someone passed away and they used to take them to this room ... [to] prepare the body, wash it down and gown and wrap ... I was scared to death of it, and I didn't know how I would feel because I'd never come in to see a dead body ... I didn't know how I would react ... I just turned off." (p. 7)</p>	<p>someone die; scared to death, had not seen a dead body/ confronting</p>	<p>confronting situations</p>	<p>death care/death experiences</p>	<p>*Managing self amidst unfamiliar situations</p>	<p>unfamiliar landscape of death and dying</p>
<p>Bree: "It will be interesting ... it is going to come and I don't have that experience. I am out in the real world now and I might be alone. It might have been better to have experienced ... it could be scary (p. 45) ... I will definitely learn from that (simulation)." (p. 47).</p> <p>Lauren: "[communication skills] definitely increased heaps, I feel like I would be able to obviously, in a tough situation ... I definitely think I would be able to say the hard things and talk about it with them, because ... we had such a good simulation ... you had to be put in that situation and you knew that it was a simulation ... but because it was so well done ... you felt like you were actually in the situation ... it felt so real ... I feel like it was the perfect way to do it because ... if I was in that situation I would definitely know how I would be able to deal with it now." (p. 20)</p>	<p>Movement of time – temporality at the end of life; looking ahead</p>	<p>Transitions in time/attending to time in simulation</p>	<p>(Thread 6) *Liminal spaces of looking ahead (looking to the future)</p>	<p>(Thread 6) *Transitions across time</p>	<p>(Thread 6) *Defining moments in time</p>
<p>Bree: "Having those actors and, in Scene Five [the dying scene], ... with the noises, because I</p>	<p>It wasn't real/</p>	<p>It wasn't real/</p>	<p>(Thread 7)</p>	<p>(Thread 7)</p>	<p>(Thread 7)</p>

<p>haven't heard those types of noises, the breathing ... I think the environment is what makes it unrealistic ... you didn't really know you were in the hospital." (p. 10)</p> <p>Hannah: "With simulation I feel uncomfortable ... it seems so staged and not real... because it is not natural to me, where in the real world ... to me it just comes naturally (p. 2) ... because it wasn't real and you had to act in a way (p. 3) ... when I am working ... I just know what to ask but when I am put in a situation like that, where I have got to think it, break it down, I struggle a bit." (p. 6)</p>	<p>Real life versus unrealistic environment</p>	<p>Simulation realism versus unrealism</p>	<p>*Managing self amidst unrealism/reality versus unreality</p>	<p>*Managing self amidst unrealism; Managing self amidst contradictions/ambiguity/real versus unreal landscapes in simulation</p>	<p>*Real versus unreal landscapes in simulation</p>
<p>Lauren: "The comfort of being with friends, you know, you can trust them, and ... you will always have someone to back you up." (p. 1)</p> <p>Claire: "I felt really comfortable ... because Lauren and I got on really well ... we kind of just talked to each other through it." (p. 38)</p> <p>Grace: "It did help, the fact that we could sit and talk, the group talk (p. 12) ... and realise that it wasn't just you." (p. 13)</p>	<p>Comfort of being with friends/ Learning from others in simulation/ working with peers and learning from peers</p>	<p>Managing self in the midst of peer learning; Finding comfort amidst working with peers/working and learning together</p>	<p>(Thread 8) *Finding comfort amidst working and learning with peers/together</p>	<p>(Thread 8) *Finding comfort amidst working and learning with peers/together</p>	<p>(Thread 8) *Finding comfort amidst learning and working together</p>

7.13 Appendix M: Table of Threads

Thread	Participants	Research Aim	Umbrella Term (Chapter Five)
Thread 1: The role of others in shaping death experiences	Holly, Luke, Renee, Louise, Bree, Lauren, Millie, Claire, Grace, James, David, Emily	RA 1 RA 2	1)
Thread 2: Attending to family at the end of life	Holly, Hannah, Grace, James	RA 1 RA 2	1)
Thread 3: Theory, practice and experience become synergised	Holly, Noah, Luke, Lauren, Millie, Simon, James, Emily, David	RA 3	2)
Thread 4: Managing self amidst negotiating difficult conversations at the end of life	Noah, Louise, Luke, Sarah, Millie, David, Ashley, Simon	RA 1 RA 2	1)
Thread 5: Managing self amidst an unfamiliar landscape of death and dying	Renee, Louise, Sarah, Grace, Poppy, James, David, Ashley	RA 1 RA 2	1)
Thread 6: Defining moments in time	Renee, Bree, Lauren, Simon, Ashley	RA 3	2)
Thread 7: Real versus unreal landscapes in simulation	Renee, Bree, Hannah, Poppy, Emily	RA 2	1)
Thread 8: Finding comfort amidst learning and working together	Lauren, Claire, Grace, James	RA 1 RA 2	1)

7.14 Appendix N: Metaphorical Quilt

		Holly		Noah				
						Luke		
			Louise					Renee
	Bree							
				Hannah				Lauren
Sarah								
						Millie		
		Grace		Claire				
	Simon						James	
				Poppy				
Ashley								Emily
			David					

Quilt Block Key	
Thread	Symbol and meaning
Thread 1: Role of others in shaping death experiences	Blue heart (trust)
Thread 2: Attending to family at the end of life	Green heart (growth)
Thread 3: Theory, experience and practice synergised	Yellow heart (mind/intellect)
Thread 4: Managing self amidst difficult conversations at the end of life	Grey heart (indecision)
Thread 5: Managing self amidst unfamiliar landscapes of death and dying	Black heart (death)
Thread 6: Defining moments in time	Purple heart (future)
Thread 7: Real versus unreal landscapes in simulation	Black & White heart (opposites)
Thread 8: Finding comfort amidst learning and working together	Pink heart (nurturing)