



Assessment of a learning intervention in palliative care based on clinical simulations for nursing students



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ABSTRACT

Background: Major deficiencies exist in undergraduate nursing education for Palliative Care. Opportunities to care for dying patients are often unavailable to students in traditional clinical settings. Palliative care simulation is an innovative strategy that may help to prepare undergraduate nursing students to provide quality palliative/end of life care. It is valuable to explore the student nurses' beliefs, feelings and satisfaction regarding the impact that simulation clinic applied to palliative care has and how it influenced their overall experience of caring for a dying patient and the patient's family. This study aimed to evaluate a learning intervention in palliative care using a low-fidelity clinical simulation for undergraduate nursing students from a Spanish university, based on the analytics of their expectations and learning objectives.

Method: Sixty-eight students participated in this mixed descriptive design study, they participated in a palliative care simulation scenario and completed three questionnaires which assess the knowledge and expectations before the simulation and the subsequent satisfaction with the performance and learning received.

Results: The intervention in question met students' learning expectations, singling out social abilities as important tools in palliative care training, and the students were satisfied with the presented case studies.

Conclusions: Our results suggest that low-fidelity clinical simulation intervention training in palliative care is an appropriate and low-cost tool for acquiring competitive skills. Learning in the simulation scenarios provides a mechanism for students to improve student communication skills.

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1. Introduction

The majority of society's deaths occur in a health care environment. Regardless of whether a death occurs in acute care, hospice, residential aged care or community settings, nurses spend the most time in direct care activities with dying patients and their family members and play a pivotal role in palliative and end of life care. Palliative care is an inter-professional discipline that aims at improving the quality of life of patients with advanced diseases and their families by addressing their symptom concerns and their communication and decision-making needs (World Health Organization, 2013). Palliative care includes caring for people who are nearing the end of life, this is called end of life care. End of life care aims to help people live as well as possible and to die with dignity (World Health Organization, 2013).

Lack of professional education has been identified as a major barrier to providing quality palliative care to patients (Van Der Eerden et al., 2014). Palliative care education in undergraduate nursing programs is minimal and does not adequately prepare new nurses to provide

high-quality palliative care (Zimmermann et al., 2008). A working group of the European Association for Palliative Care (EAPC) developed and published the results of a survey on the current situation in palliative care (PC) knowledge in more than fifty European countries (Lynch et al., 2011). This study shows that there are important barriers at all levels, such as lack of education and training. Recently, the EAPC, the International Association for Hospice and Palliative Care, the Worldwide Palliative Care Alliance and the Human Rights Watch published a report called the *Carta de Praga* ("The Prague Letter"), where they urged all governments and health authorities to integrate PC in their health care systems (Radbruch et al., 2013). They asked that health policies be reformed to include the alleviation of suffering of patients with terminal illnesses, and also emphasised the need for a change in curricula, claiming that PC training should start during undergraduate education.

The inclusion of palliative care in undergraduate education is a way of providing knowledge, skill, and competences about palliative care (especially communication) and also improving attitudes toward caring in advanced disease and at the end of life (Cavaye and Watts, 2014; Centeno and Rodríguez-Núñez, 2015). Nursing education programs often lack opportunities for palliative care experiences in undergraduate education. Limited clinical placement and shortened lengths of

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stay for patients affect the opportunities for clinical experiences with real patient care situations. The available scientific evidence suggests that curricular PC training is predominantly theoretical, and that the application of theory to practice is not rated with methodological strictness (Wallace et al., 2009). It is recommended that student's undergraduate training should include a significant amount of both didactic and clinical palliative care content. Fortunately, different innovative methods regarding palliative and end-of-life care, as simulation, are emerging in the health sciences educational system (Gillan et al., 2013; Fluharty et al., 2012; Leighton and Dubas, 2009; Kopp and Hanson, 2012; Gilliam et al., 2013; Hamilton 2010). Simulation offers an alternative learning strategy for nursing students to apply principles of palliative care and communication in a safe, interactive learning environment. Simulation is defined as “An event or situation made to resemble clinical practice as closely as possible” (Jeffries, 2012, 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, 2012, p. 28). Hence, patient simulation incorporates a range of products ranging from sophisticated computer-driven high-fidelity simulators to low-fidelity simulators and part-task trainers. Although simulation-based training is becoming more common, outcomes research on the use and effectiveness of simulation is inconsistent and varies in methodological rigor and substantive focus (Frey et al., 2013; Tosterud et al., 2013).

There are several studies using high fidelity simulation for training in palliative care (Kopp and Hanson, 2012; Hawkins and Tredgett, 2016), but there are hardly any studies using low fidelity (Shepherd et al., 2007). However we believe that the acquisition of certain skills needed in palliative care is best acquired through low fidelity, as studies indicate (Grober et al., 2004; Wilson et al., 2005). Learning how to talk to the patient and the patient's family when death is near will likely increase students' comfort level when providing palliative/end-of-life care. In a review of PC performed by Foronda et al. (2013), the authors of all reviewed studies noted that the use of clinical simulation in palliative care focuses on five factors: self-efficacy, satisfaction, stress and anxiety management, acquiring skills and knowledge, and experience in interdisciplinary teams. Furthermore, the use of low-fidelity patient simulation could be seen as a more affordable, high throughput, entry point, and process for learners in undergraduate students (Moreland et al., 2012; Schulz et al., 2014). Shepherd et al. (2007) suggests that educational activities that incorporate low-fidelity simulation are more effective than more traditional teaching modalities such as self-directed learning and didactic classroom education for teaching specific patient assessment skills to graduate nurses.

Consequently, the basis for this study was the following question: is the use of low-fidelity clinical simulation in PC training meeting the learning objectives and expectations of undergraduate nursing students who are participating in a simulation case for the first time?

The main objective of this report was to evaluate a learning PC experience using a low-fidelity clinical simulation with undergraduate nursing students from a Spanish university based on the analytics of their expectations and learning objectives. The secondary goals of this study were to explore the students' expectations and beliefs regarding PC simulation, and to survey students' satisfaction with the use of the PC low-fidelity clinical simulation method.

2. Material and Methods

This study was mixed design, combining quantitative and qualitative analysis because the two approaches are necessary to explore the students' expectations and beliefs regarding PC simulation, and the students' satisfaction with a simulation clinic experience. Participants were undergraduate nursing students in their sophomore year taking

the subject 'Performance in Special Situations'. In that subject they have been received 12 theoretical hours about PC, previously to the simulation cases.

2.1. Instruments

We used three questionnaires which combining quantitative and qualitative questions to give answer to the objectives of this research: the *Knowledge and Beliefs about PC questionnaire*, the *Participants' questionnaire* and the *Observer' questionnaire*. The three questionnaires were developed by researchers. The questions in the questionnaires are connecting with the following learning objectives: a) Examine the cultural and spiritual aspects in the terminal patient. b) Explore the needs of family members who provide care to terminally ill patients. c) Enhance teamwork and humanization in assisting patient with problems in special situations. d) Demonstrate skills that promote effective communication, interaction and involvement with the patient, groups and team members in the process of care.

2.2. The Knowledge and Beliefs about PC Questionnaire

This questionnaire assessed the students' knowledge and beliefs about previous training in PC before the simulation intervention. After a bibliographical review of the PC literature, the researchers included five open-ended questions and four Likert scale questions in this test, which was completed by all students before the beginning of the simulation.

Two other questionnaires were filled out after completion of the activity; one of these two questionnaires was to be completed only by the participant students in the case (*participants' questionnaire*), while the second one was to be filled out by the observant sophomore students (*observers' questionnaire*). Both tests had eight questions in common (seven Likert-type and one open-ended) related to the characteristics of the activity. The *participants' questionnaire* had six additional questions (three Likert-type and three open-ended) related to each participant's own performance during the activity. Meanwhile, the *observers' questionnaire* had five additional open-ended questions related to the performance of their peers. Both questionnaires were part of the debriefing itself.

The *observers' questionnaire* was previously validated in an earlier study done by the same research group, with good psychometrically valid results and reliability ($\alpha = 0.860$) (16).

The questionnaires were self-administered and anonymous, and the students were informed that participation would have no effect on their grades.

2.2.1. Design Activity

The clinical simulation (CS) was performed in the Virtual Hospital Valdecilla (Spain), a specialised center for training with clinical simulations that has a partnership with the Center for Medical Simulation in Cambridge, MA (USA). The Nursing School is in a University in the north of Spain, and it currently has an agreement with the Virtual Hospital Valdecilla to perform clinical simulations. The activities are taught by instructors specially trained in the theories of experiential learning who are certificated as CS instructors by the Institute for Medical Simulation (IMS). The PhD holder responsible for the simulation, co-author of PC simulation cases and IMS certificated, led the research group with the authors of this study.

Two scenarios based on real events were designed, using different methods of low fidelity simulation, whereby two patients diagnosed with terminal cancer were simulated: Case A, a 79-year-old woman with lung neoplasm and brain metastasis, and case B, a 60-year-old man diagnosed with gastric tumour with skin metastasis. The scenario of the first case was depicted in a hospital room, while the second scenario was depicted at the patient's home.

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