Examining Instructional Methods in End-of-life Nursing Education: Lecture vs. Simulation

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EXAMINING INSTRUCTIONAL METHODS IN END-OF-LIFE NURSING EDUCATION: LECTURE VS SIMULATION

BY

JONATHAN M. BENSON

A thesis submitted in partial fulfillment of the requirements for the
Master of Science
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THESIS ACCEPTANCE PAGE

Jonathan Benson

This thesis is approved as a creditable and independent investigation by a candidate for the master’s degree and is acceptable for meeting the thesis requirements for this degree. Acceptance of this does not imply that the conclusions reached by the candidate are necessarily the conclusions of the major department.

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As I near the completion of my thesis work and its final defense, I reflect on how I got here and owe a debt of gratitude to many. This is not a journey I could have accomplished on my own and wish to express my appreciation for those who have supported me along the way.

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Appendix A: SDSU IRB Exemption ................................................................. 42
Appendix B: Sanford IRB Phased Approval ................................................. 43
Appendix C: Recruitment Flyer ................................................................. 46
Appendix D: Demographic Questionnaire .................................................. 47
Appendix E: ELNEC Agenda ................................................................. 48
Appendix F: ELNEC with Simulation Agenda ............................................. 49
Appendix G: Simulation Documents ........................................................... 50
Appendix H: Simulation Debriefing Guide ................................................ 56
Appendix I: Copyright Permissions ............................................................ 59
Appendix J: FATCOD-B ................................................................. 65
ABBREVIATIONS

AACN – American Association of Colleges of Nursing
ELNEC – End-of-Life Nursing Education Consortium
EOL – End-of-Life
FATCOD – Frommelt Attitudes Toward Care of the Dying Scale
FATCOD-B – Frommelt Attitudes Toward Care of the Dying Scale-Form B
PC-ELNEC – Perceived Confidence in Meeting ELNEC Standards
RN – Registered Nurse
SD – Standard Deviation
LIST OF TABLES

Table 1.......................................................................................................................14
Table 2.......................................................................................................................27
Table 3.......................................................................................................................29
Table 4.......................................................................................................................29
LIST OF FIGURES

Figure 1 .................................................................................................................................................. 18
Figure 2 .................................................................................................................................................. 19
Figure 3 .................................................................................................................................................. 19
ABSTRACT

EXAMINING INSTRUCTIONAL METHODS IN END-OF-LIFE NURSING EDUCATION: LECTURE VS SIMULATION

JONATHAN BENSON

2020

Undergraduate nursing programs have historically glossed over end-of-life care, if their curricula addressed it at all. This lack of instruction can leave practicing nurses feeling poorly prepared to deliver this specialized care. Feeling incompetent and lacking confidence may lead to poorer attitudes regarding this nursing specialty. Thus, effective continuing education activities are paramount in equipping nurses to provide this care and improve attitudes towards caring for terminally ill patients and their families. The purpose of this study was to examine how registered nurse attitudes towards end-of-life care are impacted using a simulation-based learning experience compared to a traditional face-to-face lecture instructional format. A pretest-posttest control group design was used to compare the face-to-face lecture with the simulation-based learning experience. The Frommelt Attitudes Toward Care of the Dying – Form B was used to measure nurse attitudes before and after the intervention. A repeated measures analysis of the two-group pretest-posttest was conducted. Nurse attitudes increased significantly \((p = 0.003)\) in both the simulation and lecture group; there was no significant \((p = 0.879)\) difference between the groups’ increase in attitude. Both face-to-face lecture and simulation are effective in improving nurse attitudes towards end-of-life care and should be considered when designing continuing education activities.

Keywords: nursing, end-of-life care, education, simulation
Chapter One: Introduction

Advances in medicine and efficacious public health strategies have greatly improved average life expectancy in the United States. As Americans age, they are at a greater risk of death from heart disease, cancer, or other chronic condition such as diabetes or stroke (Centers for Disease Control, 2013). Moreover, the CDC (2013) reports that treatment of chronic illnesses accounts for two thirds of healthcare spending and 95% of healthcare spending for those over 65. This aging and, at times, chronically ill population has generated a new focus in healthcare: end-of-life (EOL) care. As this specialty gained attention, a knowledge gap in healthcare education became apparent.

This spotlight became an impetus for a healthcare paradigm shift, especially in nursing. In 1997, the American Association of Colleges of Nursing (AACN) released Peaceful Death: Recommended Competencies and Curricular Guidelines for End-of-Life Nursing Care to help guide historically inconsistent or absent instruction in undergraduate nursing education. These competencies led to a partnership between the AACN and the City of Hope National Medical Center. Through collaborative efforts this partnership created a national education initiative – the End-of-Life Nursing Education Consortium (ELNEC) train-the-trainer project (AACN, 2020; Ferrell et al., 2016). As of November 2019, the project is estimated to have provided EOL care education to over 738,500 professionals (AACN, 2020). Even with this impressive training for nurses, nursing students still find the act of providing EOL care stressful (Corcoran, 2016; Venkatasalu et al., 2015).

Nursing students are not the only ones needing assistance in this specialized area of care. Nurses working in different specialty areas such as medical-surgical, critical care,
or oncology will likely provide EOL care at some point in their career (Lippe & Becker, 2015). White and Coyne (2011) found that 25% of the oncology nurses in their sample felt ill prepared to care for dying patients. Schlairet (2009) reported that over 50% of nurses in a survey (n = 567) felt inadequate regarding their competency in providing EOL care.

Statement of the Problem

An undergraduate nursing textbook review conducted in 1998 revealed that of the 50 texts reviewed, only 2% of overall content related to EOL care (Ferrell et al., 1999). A recent review of 11 nursing textbooks revealed an increase in EOL content to 18% (Ferrell et al., 2016). Despite the increase in EOL content, Ferrell et al. (2016) found that some of the textbooks contained numerous gaps, errors, and misconceptions about EOL care. Given these inaccuracies, it is unlikely that this increase in content has yielded an increase in student knowledge of proper EOL care.

In 2015, 71 faculty members representing 33 states were surveyed at various national ELNEC courses. The survey assessed the presence and strength of palliative care education in pre-licensure programs as well as asked faculty to rank how prepared they believed their students were to provide palliative care at the time of graduation. On a 0 to 10 scale, with 10 signifying the most prepared, faculty scores averaged to 5.4 (Ferrell et al., 2018). Faculty also indicated that one of the reasons they did not teach palliative care was their own limited content knowledge (Ferrell et al., 2016). More education is necessary to better prepare nursing for this specialty.

The original Peaceful Death (AACN, 1997) competencies were revised to create Competencies and Recommendations for Educating Undergraduate Nursing Students
(CARES): Preparing Nurses to Care for the Seriously Ill and their Families. The CARES document includes more aspects of EOL care, such as care at time of diagnosis and across the trajectory of the illness; these new competencies also put an emphasis on nursing education (AACN, 2016). While these competencies often come through experience, they can (to a certain degree) be taught. The ELNEC initiative’s purpose is to equip healthcare professionals with the essential knowledge needed to provide quality palliative care (AACN, 2020).

It is important to note that while palliative care does encompass EOL care, the two terms are not synonymous. Palliative care is a treatment approach directed at treating symptomology and alleviating suffering (World Health Organization, 2018); it can be initiated at any point in a treatment course. EOL care specifically focuses on perimortem care delivery (Izumi et al., 2012). As EOL care is a dynamic task, multiple methodologies for instruction in competency should be explored to determine what is most helpful to the nurse. There is a gap in current knowledge of which methodology is most efficacious for the practicing nurse.

Purpose of the Study

The purpose of this study was to examine how registered nurse (RN) attitudes towards EOL care are impacted using a simulation-based learning experience integrated into the ELNEC core curricula compared to the traditional face-to-face lecture instructional format of the ELNEC core curricula.

Research Questions / Hypothesis

The research question for this study was: What is the difference between face-to-face lecture alone and simulation-based learning experience paired with face-to-face
lecture on RN attitudes towards providing EOL care? The hypothesis for this study was: The simulation-based learning experience will increase RN attitudes towards EOL care at least as much as a face-to-face lecture alone.

**Significance**

New nurses entering the profession are underprepared to provide EOL care as few programs provide adequate EOL education (Lippe & Becker, 2015). Wells et al. (2003) reported that only 3% of their respondent undergraduate nursing programs had dedicated EOL courses. The authors also state that 78% of nursing faculty had only “some comfort” (p. 32) regarding their EOL expertise. Proper EOL education in undergraduate programs is paramount in preparing new RNs for practice and its various roles.

One of nursing’s greatest roles is that of patient advocacy. This includes being an advocate during the transition from curative to palliative and/or EOL care. Rady and Johnson (2004) found that over two thirds of the patients transferred to the intensive care unit who later died there had not had alternative treatment methods discussed with them. Further, half of these patients had frequent hospitalizations in the year prior to their death as a result of known ultimately or rapidly fatal chronic disease. This may be due to patient’s (and/or their family members’) misconceptions about EOL decisions and documents such as advance directives. The nurse acting as a patient advocate is well positioned to help clarify these misconceptions as part of the care they provide during the curative to EOL care transition. (Hebert et al., 2011).

Two studies of Oncology Nursing Society members discovered that a need exists for more and better EOL education (White & Coyne, 2011; White et al., 2001). These studies also reported that a significant number of respondents had not received any EOL
continuing education in the previous two years. Schlairet (2009) reported a majority of
the nurses she sampled had no formal education nor continuing education regarding EOL
care. These nurses also had substantial knowledge deficits in 21 of the 23 EOL care
topics.

Additionally, there are financial implications when ensuring nurses are adequately
prepared to provide palliative and EOL care. In the United States, Medicare is the largest
single purchaser of personal healthcare, spending $663 billion in 2016. The sickest 8% of
Medicare’s enrollees account for almost 18% of its healthcare expenditure (MedPAC,
2018). Isenberg et al. (2017) found that appropriate palliative care resulted in a 25% cost
reduction when compared to traditional medical care. They also reported that Johns
Hopkins Medical Institutions saved over $3 million in 2013 as a result of inpatient
palliative care and palliative care team consultations.

Since the quality of undergraduate EOL education remains in question, it is
difficult to predict how well practicing nurses are prepared to deliver this unique care.
Feeling inadequately prepared to deliver this type of care may negatively impact nurses’
feelings towards this specialty. Determining what teaching methodology works best for
practicing RNs will allow for better instruction in EOL care so continuing education
hours can be most beneficial and improve RNs’ attitudes towards EOL care. Well-
designed continuing education courses are critical in positively influencing nurses’
knowledge, skills, and attitudes regarding specialty areas, such as EOL care. With
increased confidence and competence, nurses are able to provide quality EOL care to
patients and support their families during this difficult transition.
Definitions

End-of-life – encompassing a period prior to a person’s death. This time may include palliative care and hospice as well as the moments immediately preceding the person’s death (Izumi et al., 2012).

Face-to-face lecture – an instructor provides in-person lectures to provide training (Corcoran, 2016). In this study, the face-to-face lecture will be delivered by subject matter experts teaching material from the six ELNEC core modules.

Palliative care – treatment approach to life-threatening illness that improves quality of life through prevention and relief of suffering by early identification, assessment, and treatment of pain as well as physical, psychological, and spiritual problems. Palliative care does not hasten or postpone death, but rather affirms life and sees death as a normal process (WHO, 2018).

Registered nurse – an individual that has graduated from an approved pre-licensure RN program, passed the National Council Licensure Examination – Registered Nurse (NCLEX-RN), and has met and continues to meet his or her state’s licensure requirements (National Council, 2018).

Simulation – planned experience that includes a pre-briefing stage, interaction with a simulation mannequin, and a debriefing stage (Venkatasalu et al., 2015).
Chapter Two: Review of Literature and Conceptual Framework

A systematic literature review conducted from 2008 to 2018 within EBSCOhost, CINAHL, and Ovid yielded over 2,000 articles. Search terms included: end-of-life, education, end-of-life education, end-of-life care, simulation, end-of-life education and simulation, and nursing education. Only scholarly articles written in English from peer reviewed journals were considered for this review, narrowing the literature to several hundred articles. Article titles were briefly reviewed for pertinence, yielding 50 articles. Those articles without full text available to the researcher were excluded from review. The remaining 45 abstracts were reviewed for relevancy to the study. Relevance was determined by the researcher with seven articles selected for inclusion. Additionally, another article from 2001 was selected for inclusion as it provided historical context for an included article. A brief overview of the included literature can be seen in Table 1.

After completing the initial review of the literature, a need to further explore the historical context of views on death and dying was identified. A brief review of the literature was conducted using the databases listed above and multiple queries used the following search terms – death and dying, death culture, dying in America, and death denying culture. Again, only peer reviewed sources in the English language were considered, although some laxity was given to publication date to ensure an adequate historical perspective was garnered.

Additional queries of the literature were completed in July of 2020 to determine if there were any new articles that should be include in this review. Several articles were identified that pertained to the body of evidence presented below, although none provided a meaningful addition. Reasons for not including these articles include focusing on
nursing students rather than practicing nurses and examining communication rather than nurse attitudes.

**Perspectives on Death and Dying**

Over the last century societal views on death and dying in the United States have shifted. Death once commonly occurred in the home under the care of relatives, resulting in many people having a personal knowledge of the dying process. Advances in medicine have allowed for treating illness and extending life, which has allowed death to become an institutionalized and technological process (Institute of Medicine Committee, 1997). While proportionally the number of individuals that die in hospitals has been declining recently, there are still frequent hospitalizations in the final months of life (Institute of Medicine, 2015). Advances in medical technology have allowed for better support and more intensive monitoring, resulting in higher expectations for positive outcomes from patients and their families (Cox, 2018). These expectations have ingrained in healthcare providers that death should be avoided and created a death denying society – death is a failure of the medical system (Tucker, 2009). This paradigm is changing to include palliative medicine and dying with dignity (Institute of Medicine Committee, 1997).

**Nursing Student Simulations**

Lippe and Becker (2015), Dame and Hoebeke (2016), and Venkatasalu et al. (2015) focused on using simulation experiences to improve undergraduate student nurses’ EOL education. All three studies indicated simulation was effective in EOL education. Two of these studies examined how attitudes towards EOL care could be impacted using simulation (Dame & Hoebeke, 2016; Lippe & Becker, 2015), and one also explored

**Lippe and Becker**

Lippe and Becker’s (2015) quasi-experimental study implemented an EOL simulation experience and evaluated its effectiveness using a pretest-posttest on a convenience sample of 118 baccalaureate and nine associate’s-to-bachelor’s nursing students in three differing cohorts. The first cohort was composed of both baccalaureate and associate’s-to-bachelor’s students, while cohorts two and three contained only baccalaureate students. Their measurement instruments included the Frommelt Attitudes Toward Care of the Dying scale (FATCOD) and a tool developed for the study to measure perceived confidence in meeting ELNEC standards: PC-ELNEC. The authors saw increases in posttest scores in all cohorts for PC-ELNEC ($p < 0.01$) and increases in two cohorts for FATCOD ($p < 0.05$).

The FATCOD means and standard deviations were reported as follows: cohort one had a pretest mean of 124.95 with a standard deviation of 9.94 and posttest mean of 124.84 with a standard deviation of 8.51; cohort two had a pretest mean of 122.66 with a standard deviation of 9.29 and a posttest mean of 128.94 with a standard deviation of 10.62; cohort three had a pretest mean of 120.51 with a standard deviation of 9.63 and a posttest mean of 126.51 with a standard deviation of 9.54 (Lippe & Becker, 2015). While it is likely these increases are due to the simulation, this conclusion could have been strengthened by including a control group.
Dame and Hoebeke

Dame and Hoebeke’s (2016) quasi-experimental study used a one group pretest-posttest evaluation of an EOL simulation. This single group was a convenience sample of 57 second semester baccalaureate nursing students who completed the Frommelt Attitude Toward Care of the Dying Scale-Form B (FATCOD-B) tool to determine results. The authors reported significant findings ($p < 0.001$) with a pretest mean of 4.05 and a posttest mean of 4.21. The results again indicate that simulation is responsible for improving attitudes toward EOL care, although lack of a control group limits the exploration of potential confounding factors.

Venkatasalu et al.

Venkatasalu et al. (2015) completed a qualitative phenomenographic study of a convenience sample composed of 187 first-year nursing students. These students were randomly assigned to one of two groups: one would receive EOL training using a high-fidelity simulation ($n = 48$), the other would use traditional classroom-based education ($n = 139$). Additional inclusion criteria included that the student must have an EOL care experience during their clinical; 12 students met this criterion, five from the classroom group and seven from the simulation group. After receiving their training and upon returning from the first clinical placement, semi-structured interviews were conducted and themes extracted. Both groups noticed an increase in EOL knowledge, but the simulation group reported an increase in practical skills and in improved emotional experience. The inclusion of a control group with this study allows for differences in the simulation group to be more clearly identified. However, these differences were not assigned a quantity for comparison, so it is difficult to truly determine effectiveness.
**Interprofessional Simulation**

Gannon et al. (2017) examined the impact of interprofessional simulation on pharmacy and graduate nursing students’ attitudes towards EOL care. Pharmacy students \( (n = 158) \) on three campuses were exposed to paper EOL case studies and completed a pretest-posttest to determine a change in attitude toward EOL care. On a fourth campus, pharmacy students \( (n = 37) \) and Doctor of Nursing Practice students \( (n = 8) \) were paired and completed a simulated version of the same case studies. This fourth group also completed the same pretest-posttest as the other three. The instruments used for the tests were the End of life Professional Caregiver Survey (EPCS), which measures perceived skill in EOL care, and the Readiness for Interprofessional Learning Scale (RIPLS). All four groups showed improvement of attitudes towards EOL care on the posttest; however, there was no significant difference among the posttest scores of the three paper only groups. When compared to the paper only group, the simulation group had significantly higher posttest scores. The researcher’s data suggest the difference between the fourth group’s and the other three groups’ posttest scores is due to simulation and not the interprofessional interaction.

**Face-to-Face Seminar**

Corcoran (2016) examined the implementation of a face-to-face seminar aimed at improving comfort level regarding EOL care. This seminar was composed of three ELNEC modules and was open to multiple healthcare disciplines. Participating disciplines included nursing, spiritual care, dietetics, case management, physical therapy, and education. Participants completed a survey three weeks prior to the seminar and again three weeks after the seminar. Of the 55 pretests completed, only 30 could be
matched to a posttest. The reported pretest mean was 67.3 and posttest mean was 81.5. The researcher concluded the significant ($p < 0.001$) increase in scores from pretest to posttest indicated that ELNEC modules are effective in improving healthcare providers’ comfort levels regarding EOL care.

**Historical RN Education Needs**

White et al. (2001) conducted a descriptive study focused on identifying EOL care education gaps among oncology nurses. Surveys were mailed to members of the Oncology Nursing Society in the states of Georgia, Virginia, Washington, and Wisconsin. The surveys asked respondents about EOL continuing education and to rank EOL core competencies they wished would have learned more about in nursing school. This study yielded a return rate of 33% for total of 760 surveys, 750 of these were deemed usable for the study. Survey responses were collated, identifying the priority area of EOL care education to be discussing death/dying with patients/families. An overwhelming majority (98%) of respondents indicated that EOL education was important but over 25% had no EOL education in the last two years. A quarter of those who had received continuing education rated it fair to poor in quality.

White and Coyne (2011) followed up the White et al. (2001) study with another descriptive study. Surveys were mailed and emailed to the same sample group described above. This survey included additional questions and relabeled one of the core competencies but otherwise remained similar to the original survey. The return rate for this study was 30%, yielding a total of 765 responses; of these responses, 714 were deemed usable. The priority area of EOL care education this study identified was symptom management. A third of respondents had not received EOL education in the
prior two years, and among those receiving education, 17% indicated its quality as fair to poor. Despite there being 10 years between these studies, it is concerning that there appears to be no progress regarding EOL education.

Schlairet’s (2009) descriptive study also focused identifying RNs’ EOL educational needs but used RN’s from the state of Georgia as a sample rather than the specialty group of oncology nursing. A survey was published in the state nurses association’s paper reaching an estimated 51,000 nurses; 567 returned surveys were valid, for a response rate of 1.1%. Demographic information indicated only 33% of respondents had received formal EOL education during their initial nursing education. One of the sections of the survey asked nurses to rank their competency in 23 EOL care areas. In 21 of the 23 EOL content areas, more than half of respondents rated themselves as less than competent.

Summary

While the descriptive studies above may lack rigor by their very nature, one theme is abundantly clear: there is ample room for improvement in both the type and number of EOL educational opportunities available to RNs and those going through nursing programs. There are several education gaps and a need for more formal education as well as continuing education in EOL care. Both simulation and face-to-face lecture are associated with improving perceptions and attitudes regarding EOL care. There currently is no published research to identify the most effective instructional strategy between face-to-face lecture and simulation-based learning experience as it impacts RN’s attitudes towards providing EOL care.
Table 1

*Literature Review Overview*

<table>
<thead>
<tr>
<th>Citation</th>
<th>Type of Study</th>
<th>Type of Subjects</th>
<th>Variables</th>
<th>Tools</th>
<th>Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Corcoran, 2016</td>
<td>Quasi-experimental</td>
<td>Healthcare professionals</td>
<td>EOL workshop</td>
<td>EPCS</td>
<td>Posttest scores &gt; pretest scores</td>
</tr>
<tr>
<td>Dame &amp; Hoebeke, 2016</td>
<td>Quasi-experimental</td>
<td>Nursing students</td>
<td>EOL simulation</td>
<td>FATCOD-B</td>
<td>Posttest scores &gt; pretest scores</td>
</tr>
<tr>
<td>Gannon et al., 2017</td>
<td>Quasi-experimental</td>
<td>Nursing and pharmacy students</td>
<td>Case studies vs. simulation</td>
<td>EPCS RIPLS</td>
<td>Both had increase in attitudes towards EOL care with simulation-group having greater increase</td>
</tr>
<tr>
<td>Lippe &amp; Becker, 2015</td>
<td>Quasi-experimental</td>
<td>Nursing students</td>
<td>EOL simulation</td>
<td>FATCOD PC-ELNEC</td>
<td>Posttest scores &gt; pretest scores</td>
</tr>
<tr>
<td>Schlairet, 2009</td>
<td>Simple descriptive</td>
<td>RN’s</td>
<td>None</td>
<td>Survey</td>
<td>Survey indicates lack of formal education and lack of competency</td>
</tr>
<tr>
<td>Venkatasalu et al., 2015</td>
<td>Qualitative phenomenography</td>
<td>Nursing students</td>
<td>Classroom vs Simulation</td>
<td>Interviews</td>
<td>Both had increase in EOL knowledge. Simulation group also had increase in skills and emotions</td>
</tr>
<tr>
<td>White &amp; Coyne, 2011</td>
<td>Simple descriptive</td>
<td>Oncology nurses</td>
<td>None</td>
<td>Survey</td>
<td>Survey demonstrates lack of quality education</td>
</tr>
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<td>Oncology nurses</td>
<td>None</td>
<td>Survey</td>
<td>Survey demonstrates lack of quality education</td>
</tr>
</tbody>
</table>
Conceptual Framework

The proposed study is built upon a solid framework intertwined by three theories. Andragogy forms the basis of adult learning, so its principles will be present throughout this study’s framework. Kolb’s (1984) experiential learning theory provides the overarching framework for this study. Tanner’s (2006) clinical judgment model will guide the simulation debriefing.

Andragogy

Malcom Knowles proposed his theory of andragogy in 1968 as the science of adult learning. Andragogy posits that adults are self-directed with internal motivation, possess experiences that they can apply to learning, must know why something must be learned, and prefer problem centered learning (Clapper, 2010). One of the central tenets in andragogy is that learners assume responsibility for their own learning. This is most easily accomplished when the learner can relate their past experiences to what is being learned or relate the information to their profession (Sadera et al., 2014). Figure 1 illustrates Knowles’ theory.

As adult learners are self-directed, it is important that the educational activities they seek out are meaningful. This study centered on determining what instructional methodology would be most meaningful to the practicing nurse when learning about EOL care. The simulation-based learning experience utilized problem centered learning and required learners to reflect on past experiences.

Experiential Learning Theory

Kolb (1984) presented experiential learning theory as a holistic learning perspective integrating experience, perception, cognition, and behavior. Building on the
works of Lewin, Dewey, and Piaget, Kolb’s theory emphasizes the role experience has on learning; experiential learning theory views learning as a process and not a behavioral outcome. To be effective learners, students must have an abstract experience, reflective observation, abstract conceptualization, and active experimentation. For example, a learner must be able to have a new experience, reflect on this experience and his or her observations, create concepts based on these observations, and apply these concepts to solve problems (Kolb, 1984). A graphic representation of experiential learning theory is shown in Figure 2.

Poore et al. (2014) posit that simulation is an application of Kolb’s (1984) theory. The planned simulation experience represents the abstract experience. Learners reflect during the simulation as well as in the debrief phase; it is also during the debrief phase where learners begin to form concepts as they think about what occurred and what could have been done differently. Finally, active experimentation is complete when learners apply these new concepts in future simulations or to work/clinical experiences (Poore et al., 2014).

The simulation-based learning experience used in the comparison group of this study offered multiple applications of experiential learning. As the unfolding scenario progressed, learners had the opportunity to move through each of the phases discussed above. Each individual scenario was a new experience followed by a debriefing. The debriefing encouraged active reflection and promoted concept development. These concepts could then be applied during the next scenario; the concepts developed during the final debriefing can serve as a cumulative learning experience which can be put into practice the next time the nurse provides EOL care.
**Tanner Model**

The Tanner model is based on nearly 200 studies of clinical judgment and presents a more complex problem-solving method than the traditionally presented nursing process of assess, plan, implement, and evaluate. In contrast, the Tanner stages are noticing, interpreting, responding, and reflection (see Figure 3). In the noticing phase, learners’ expectations will give them an initial grasp of the situation. This grasp leads into how learners will begin to interpret and then respond to the experience at hand. Learner actions lead to outcomes, which are reflected on in the moment and may lead to intervention modification. Later reflection on actions leads to clinical learning and forms the basis for new expectations for future experiences (Tanner, 2006). These stages will be used post-simulation during debriefing to help learners with abstract conceptualization.

The simulation-based learning experience required learners to use clinical judgment to progress through the scenarios. Each scenario was designed to have the learner to notice a concern, interpret and respond to that concern, and reflect on how their response impacted the original concern. To help guide reflection and responses, cues were also built into each scenario; if these cues were not interpreted appropriately, this was discussed in the debriefing phase to determine what else the learner was noticing or interpreting.
Figure 2. Experiential Learning Theory. Image Retrieved from
https://www.simplypsychology.org/learning-kolb.html

Figure 3. Tanner Model. From “Tanner’s Model of Clinical Judgment
Applied to Preceptorship: Part 1” by M. B. Modic, 2013, Journal for Nurses in

(https://doi.org/10.1097/01.NND.0000433907.85137.2e). Copyright 2013 by Wolters
Chapter Three: Method and Procedures

This chapter will review the design, sample, and setting of the study. The procedure, measurement tool, and analysis will also be discussed. This study examined how RN attitudes towards EOL care are impacted using a simulation-enhanced learning experience compared to traditional face-to-face lecture.

Two distinct groups of subject matter experts were used in this study: simulation experts and palliative care experts. The palliative care subject matter experts are all ELNEC trained and work on the palliative care team. Two of these experts are certified in hospice and palliative nursing, including a clinical nurse specialist. The simulation subject matter experts included the health system’s direction of simulation and a certified healthcare simulation educator that has published multiple times on the subject.

Research Design

This study followed a quasi-experimental pretest-posttest control group design; its rigor was influenced by use of a convenience sample and lack of randomization. Both the control group and the comparison group completed the pretest and posttest. The control group attended an ELNEC course as an eight-hour seminar composed of face-to-face lectures from subject matter experts. The comparison group attended a revised ELNEC course: an eight-hour seminar composed of face-to-face lecture from subject matter experts and an EOL simulation-based experience.

Sample

The sample was composed of RN nursing staff of a tertiary care center located in the Midwestern United States. The inclusion criteria were predetermined to include all
consenting RNs participating in an ELNEC course. As sample size was already expected to be small, there was not any exclusion criteria.

A priori power analysis was conducted using: $\alpha = 0.05$, a power of 0.8, and small (0.2) effect size. Based on this analysis and assuming an equal ratio of subjects per group, the analysis yielded a goal sample size of 325 subjects per group. Increasing the effect size to medium (0.5) yielded an ideal sample size of 53 subjects per group, again assuming equal numbers of subjects per group. Under these same assumptions, a large effect size (0.8) yielded an ideal sample size of 21 subjects per group. Given the time constraints of this study, none of these thresholds were met. The control group contained six subjects, and the comparison group contained 17 subjects.

**Study Setting**

The study was conducted at 545-bed tertiary care facility in the Midwestern United States in a city with a population of approximately 250,000. The hospital offers multiple specialty areas and has an attached emergency department with a level II trauma center as designated by the American College of Surgeons. The staffing ratios of patient-to-nurse on the medical-surgical floors is typically 4:1, with critical care areas decreasing to 2:1 and 1:1 depending on acuity. The interventions were held at the hospital’s leadership, education, and development center, which has classroom space available for the face-to-face lecture as well as a high-fidelity simulation center with an adjacent space specific for debriefing.

The simulation center has two suites set up as inpatient hospital rooms. These rooms contain equipment commonly seen in the acute care hospital setting such as monitoring devices, oxygen, wall suction, etc. Both suites have the capability of live
video broadcasting to the debriefing room so that those not actively participating in the simulation can still be involved and learn through observation.

**Study Procedure**

Permission to conduct this study was sought from the South Dakota State University Human Subjects Committee and the Sanford University of South Dakota Medical Center institutional review board. The South Dakota State University Human Subjects Committee deemed the study exempt from further board review as seen in Appendix A. The Sanford Medical Center review board approved the study in phases as indicated in Appendix B.

After approval was obtained, subjects were recruited from RNs participating in an ELNEC course. The course was offered four times per year: twice in the spring and twice in the fall. After the completion of this study, the course offerings switched to once per quarter. Past enrollment in this course was variable and ranged from 2-18 participants per course. The researcher was present and conducted all recruiting efforts through packet distribution to all nurses in the course. The packet contained a cover page (Appendix C), the demographic questionnaire (Appendix D), and the measurement tool FATCOD-B.

The cover page of the packet invited subjects to participate in the study and offered light refreshments as compensation for their participation. If individuals chose not to participate in the study, they were still welcome to refreshments and attended the educational activity alongside study participants; there were not any participants that declined to participate in this study. The cover page was also used to obtain informed consent.
The control group was recruited from the two ELNEC courses offered during the spring of 2019. Subjects who voluntarily agreed to participate in the study completed the pretest prior to the start of the seminar. After all pretests were completed, the subject matter experts delivered the face-to-face lectures according to the agenda found in Appendix E. After the final lecture, subjects were asked by the researcher to complete the posttest as a final evaluation.

The comparison group was recruited from the two ELNEC courses offered in the fall of 2019, with subjects completing the pretest prior to the subject matter experts delivering the first lecture. After all lecture material was delivered, subjects participated in the simulation-based experience as noted in the agenda found in Appendix F.

This planned simulation experience was written in the summer of 2019 by the researcher in collaboration with both groups of subject matter experts. The creation of the simulation scenario was guided by upholding the International Nursing Association for Clinical Simulation and Learning Standards of Best Practice: SimulationSM (2016). The simulation is an unfolding scenario that follows a patient needing rehospitalization for pain control and progresses to her eventual death; the full scenario can be found in Appendix G. Each scenario allowed for approximately 20 minutes in the simulation suite, with additional time devoted to pre-briefing (5 minutes) and debriefing (30-50 minutes). For each scenario, only 2-3 nurses actively participated in the simulation while the remainder observed from the debrief room via live video broadcast. The plus-delta model was used for debriefing guided by the documents in Appendix H.

The posttest was completed after the third scenario and final debriefing. The tests were administered via paper-and-pencil. To allow matching of pretests and posttests and
protect anonymity, subjects in both groups were asked to code their own surveys using the first three letters of their mother’s maiden name and last three numbers of their phone number.

**Instruments**

Demographic data were collected prior to the pretest. Data points included: gender, ethnicity, age, education level, years of nursing experience, prior EOL experience, prior formal EOL education, and nursing specialty. The demographic questionnaire items for gender, EOL experience, EOL education, and nursing specialty yielded nominal data. Ordinal data was collected from the items related to age and years of experience. Totals, means, and ranges were examined for descriptive purposes.

The tests also contained the measurement tool FATCOD-B. The tool was originally developed by Katherine Frommelt in 1989 to measure nurse attitudes towards terminally patients and their family members. This tool was found to have a content validity index of 1.00 and an interrater agreement of 0.98 When assessing reliability, the tool was found to have a Person coefficient of 0.90 (Frommelt, 1991).

In 2003, the original tool was revised to be applicable to multiple disciplines and named Form B. The FATCOD, Form B is a 30-item survey that utilizes a five-point Likert scale (1 = *strongly disagree* to 5 = *strongly agree*) measuring attitudes toward care of the terminally ill and their families; lower scores are associated with poorer attitudes toward care of the dying (Frommelt, 2003). Frommelt assessed the FATCOD-B using a content validity index and an interrater agreement of 1.00 established the tool’s validity. In assessing reliability, she found that the FATCOD-B had a Pearson coefficient of 0.9269. This tool is copyrighted, and permission has been granted to use it for data
collection. A separate permission statement was granted for republication as seen in Appendix I. The tool can be seen in Appendix J.

**Analysis**

This study explored the relationship between two variables: the independent variable of simulation-based learning and the dependent variable of RN attitudes towards care of the dying. The mean pretest and mean posttest scores for each group were examined, as well as the mean difference in pretest to posttest score. The researcher consulted with a statistician to ensure accurate analysis and appropriate test application.

The FATCOD-B tool yields ordinal data and delivers a total score based on a summation of the 30 items. This 30-item summation allows for an assumption of a normal distribution despite the small sample size. Microsoft Excel was used to run descriptive statistics on the researcher’s password protected personal computer, while the statistician used IBM’s Statistical Package for Social Sciences to conduct a repeated measures analysis of two-group pretest-posttest.
Chapter Four: Results

The research question for the study was: What is the difference between face-to-face lecture alone and simulation-based learning experience paired with face-to-face lecture on RN attitudes towards providing EOL care? The hypothesis for this study was: The simulation-based learning experience will increase RN attitudes towards EOL care at least as much as a face-to-face lecture alone. This chapter will review the results obtained from the demographic questionnaire and the FATCOD-B tool. Results for both the control group and the comparison group will be presented. A description of the analysis of the results will also be provided.

Description of Study Sample

Nursing staff of a tertiary midwestern hospital that had chosen to attend an ELNEC class made up this convenience sample. As the study sample was expected to be small, there were no exclusion criteria. The sample was composed of 23 total nurses – six in the control group and 17 in the comparison group. In the comparison group, two posttests could not be matched to their pretest and were excluded from data analysis. A summary of demographic information can be found in tables 2 and 3. No comparative statistics were run on the demographic composition of the groups as it was unclear how meaningful this could be given the small sample size.

There are two events that may explain uneven size of the control and comparison groups. There was adverse weather on the date of the first ELNEC course the control group was being recruited from that prevented some potential participants from attending. After the second date from which the control group was recruited from a glitch was noted in the learning management system used for course enrollment. This glitch prevented
potential participants from signing up for the class. Either event alone could have contributed to the lower numbers in the control group, but the combination likely negatively impacted the number of participants in the control group.

**Nursing Specialties**

The nursing staff in the control group reported the following nursing specialties: medical oncology \( (n = 4) \), pulmonary \( (n = 1) \), surgical renal \( (n = 1) \), and acute dialysis \( (n = 1) \). In the comparison group the nursing staff reported the following nursing specialties: medical oncology \( (n = 6) \), intensive care \( (n = 2) \), palliative care \( (n = 1) \), hospice \( (n = 1) \), rescue \( (n = 1) \) orthopedics \( (n = 1) \), float \( (n = 1) \), pulmonary \( (n = 1) \), and family nurse practitioner \( (n = 1) \). Several of the participants indicated multiple specialties, as such the number of specialties were reported may differ from the total number of participants. Additionally, the sample included two participants that did not indicate a specialty.

**Table 2**

**Sample Demographics: Gender and Education**

<table>
<thead>
<tr>
<th></th>
<th>Gender</th>
<th>Prior EOL(^a) Education?</th>
<th>Highest Degree</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Female</td>
<td>Male</td>
<td>Yes</td>
</tr>
<tr>
<td>Control ((n = 6))</td>
<td>83.3%</td>
<td>16.7%</td>
<td>33.3%</td>
</tr>
<tr>
<td>(n = 5)</td>
<td>(n = 1)</td>
<td>(n = 2)</td>
<td>(n = 4)</td>
</tr>
<tr>
<td>Comparison ((n = 15))</td>
<td>93.3%</td>
<td>6.7%</td>
<td>26.7%</td>
</tr>
<tr>
<td>(n = 14)</td>
<td>(n = 1)</td>
<td>(n = 4)</td>
<td>(n = 11)</td>
</tr>
</tbody>
</table>

\(^a\)End-of-Life. \(^b\)Associate’s Degree in Nursing. \(^c\)Bachelor’s Degree in Nursing. \(^d\)Master’s Degree in Nursing
**Age and Experience**

For the control group, the age range was 23-66 years old, with a mean age of 34.7 and a standard deviation of 16.2 years. This group’s experience ranged from 1.5-13 years of nursing experience, with a mean 4.3 years of nursing experience and a standard deviation of 4.4 years. Half of these nurses reported some type of EOL nursing care experience before taking the ELNEC class. All nurses in this group were baccalaureate prepared, and many \( n = 4 \) did not have any type of formal EOL care education. The two with prior EOL education reported that it had come during nursing school.

In the comparison group the age range was 22-56 years old, with a mean age of 36.9 and a standard deviation of 12.9 years. The years of experience for this group ranged from 0.8-34, with mean of 10.5 years of nursing experience and standard deviation of 9.9 years. A majority \( n = 12 \) of this group reported previous EOL care experience. Many \( n = 11 \) also reported never having received any formal EOL care education and only one reported receiving this type of education in nursing school. The educational background of this group mostly \( n = 13 \) baccalaureate prepared; master’s \( n = 1 \) and associate’s \( n = 1 \) degrees were also reported.

It is important to note that age and years of experience are not necessarily correlated. This can be accounted for when considering nontraditional students, accelerated nursing programs, or individuals choosing nursing as a second career. Another important distinction should be made between years of nursing experience and likelihood of prior EOL care experience. Some nursing specialties may never provide EOL care whereas another specialty focuses solely on EOL care, and it is possible for a new nurse to be hired in this type of specialty.
Table 3

Sample Demographics: Age and Experience

<table>
<thead>
<tr>
<th></th>
<th>Mean Age</th>
<th>Mean years of Nursing Experience</th>
<th>Given EOL\textsuperscript{a} care Prior?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Control \textsuperscript{(n = 6)}</td>
<td>34.7</td>
<td>4.3</td>
<td>yes</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>50% (n = 3)</td>
</tr>
<tr>
<td>Comparison \textsuperscript{(n = 15)}</td>
<td>36.9</td>
<td>10.5</td>
<td>no</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>20% (n = 3)</td>
</tr>
</tbody>
</table>

\textsuperscript{a}End-of-Life.

Diversity

The ethnic composition of both the control and comparison groups was white. Both groups were predominantly female. The control group and the comparison group each had one male participant.

Table 4

\textit{FATCOD-B\textsuperscript{a} Results}

<table>
<thead>
<tr>
<th></th>
<th>Pretest Mean (SD)b</th>
<th>Posttest Mean (SD)</th>
<th>Mean Pretest-Posttest Difference (SD)</th>
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</thead>
<tbody>
<tr>
<td>Control</td>
<td>118.17 (9.26)</td>
<td>124.5 (12.14)</td>
<td>6.33 (6.65)</td>
</tr>
<tr>
<td>Comparison</td>
<td>123.93 (9)</td>
<td>130.87 (10.52)</td>
<td>6.93 (8.47)</td>
</tr>
</tbody>
</table>

\textsuperscript{a}Frommelt Attitudes Toward Care of the Dying Scale-Form B. \textsuperscript{b}Standard Deviation.

Results

In the control group, the FATCOD-B pretest scores ranged from 110-136. The mean pretest score was 118.17 with a standard deviation of 9.26. The mean posttest scores ranged from 112-146 for this group, with a mean of 124.5 and a standard deviation of 12.14. The mean difference from pretest to post test was 6.33 with a standard deviation of 6.65.
The comparison group’s FATCOD-B pretest scores ranged from 113-139. They had a mean pretest score of 123.93 with a standard deviation of 9. The posttest scores for this group ranged from 114-146, with a mean posttest score of 130.87 and a standard deviation of 10.52. The mean difference from pretest to posttest was 6.93 with a standard deviation of 8.47. A comparison of the groups’ scores can be found in table 4.

**Analysis**

A repeated measures analysis of the two-group pretest-posttest was conducted using IBM’s Statistical Package for Social Sciences. This analysis showed there was not a significant interaction of group and time – the average difference in pretest-posttest scores between the control and comparison group was not significant ($p = 0.879$). The repeated measures analysis also did not show a significant difference in group main effect – the control group is not significantly different than the comparison group ($p = 0.189$). The analysis did show a significant difference in time main effect – the average pretest-posttest difference is significant ($p = 0.003$).

This analysis yields three findings important to answering the research question for this study. The significant difference in time main effect indicates that both lecture and lecture plus simulation had an impact on nurse attitudes. Finding no significant group main effect illustrates that the average nurse attitude was similar in both groups. Not finding a significant interaction between group and time shows that the average change in attitude is similar in both lecture only and lecture plus simulation.
Chapter Five: Conclusions

This chapter will discuss conclusions based on the results and analysis described in the previous chapter. The implications of these conclusions will also be discussed along with the limitations of this study. Finally, recommendations for additional research will be detailed.

Conclusions

The research question for the study was: What is the difference between face-to-face lecture alone and simulation-based learning experience paired with face-to-face lecture on RN attitudes towards providing EOL care? It was hypothesized that the simulation-based learning experience would increase nurse attitudes towards EOL care at least as much as the face-to-face lecture alone. The evidence seems to support this hypothesis as there was no significant difference ($p = 0.879$) between the mean difference of pretest-posttest scores among the control group and the comparison group.

As there was a significant difference in time main effect ($p = 0.003$), the evidence suggests that both instructional methodologies were effective at improving nurse attitudes towards EOL care. When considered with no significant difference in group main effect ($p = 0.189$) and no significant interaction of group and time ($p = 0.879$), the research question can be answered. The evidence does not support a significant difference between face-to-face lecture alone when compared to face-to-face lecture paired with a simulation-based learning experience on improving RN attitudes towards EOL care.

Implications

Demographic data from this study continue to illustrate findings from prior studies (Schlairat, 2009; White et al., 2001; White & Coyne, 2011) and the problem
discussed in chapter 1. While many nurses are providing EOL care, few have received any education or specialized training that would prepare them to confidently do so. Without adequate preparation to provide this type of care, it is possible that nurses’ attitudes toward providing EOL care may be adversely impacted. This could manifest itself in a variety of ways and should serve as an impetus to ensure quality EOL care education is being offered to practicing nurses.

The aim of this study was to examine instructional methodologies used to provide EOL care education and determine best practice. This determination could be used to create well-designed EOL care educational events that more positively influences nurses’ knowledge, skills, and attitudes. Previous studies have demonstrated simulation to be effective in providing EOL care education to nursing students (Dame & Hoebeke, 2016; Gannon et al., 2017; Lippe & Becker, 2015; Venkatasalu et al., 2015) and lecture to be effective in educating healthcare professionals (Corcoran, 2016). The data from this study did not support a clear superiority of one methodology for practicing nurses when comparing face-to-face lecture alone and face-to-face lecture paired with a simulation-based learning experience. While the data did not find a significant statistical difference in instructional methodology the subject matter experts have expressed a desire to include simulation in future ELNEC courses so there may be some clinical significance.

Limitations

Although every attempt was made to maintain rigor throughout this study, it is not without its limitations. The following limitations should be noted:

1. This study used a convenience sample and lacked randomization. The sample was recruited from RNs attending an ELNEC class in the spring and fall of 2019
to be used as the control group and comparison group, respectively. The inherent nature of how these classes were set up and scheduled made randomization difficult. The simulation-based learning experience was still being developed at the time the control group was being recruited making randomization impossible for this study.

2. The sample size was small and did not meet any of the thresholds determined in the a priori analysis. Due to the time constraints of the study, the sample size was expected to be small. The events mentioned in the beginning of chapter 4 also likely contributed to the small sample size.

3. The homogeneity of a majority of the sample makes the results difficult to generalize to a larger population. The sample was predominantly female and did not have any ethnic diversity.

4. The researcher is an employee of the facility where the study took place. Several of the study participants have worked with the researcher. This could have created a confounding variable that is not accounted for in analysis.

5. The study used paper-and-pencil to collect response data. Data were then reviewed and entered by the researcher. Although data entry was cross-checked and every effort was made to be precise, human error may have accounted for data entry errors which could have impacted the results.

6. During data entry, a flaw was noted in the design of the research tool. One of the items was split over two pages – the question was on the bottom of one page and the answer on the top of another. This flaw led to the item not being marked on several questionnaires. This missing data could have impacted the results.
7. The research tool only contained a Likert scale and did allow for narrative feedback. The researcher received commentary from participants that was not captured in the questionnaire and could not be reflected in the results.

8. As mentioned previously the research tool is copyrighted and while permission was granted for its use in data collection, limits were set on its use. One of these limits was the use of print copies only, which prevented electronic data collection.

9. The posttest was administered immediately after the intervention which limits the usefulness of time main effect. It is possible that if the posttest had been administered at a later time (days to months), the time main effect may not have been significant. The restrictions placed on the use of the research tool noted above contributed to the timing of posttest administration.

**Recommendations for Further Research**

Many of the limitations of this study can be derived from the sample size and data collection. Future research should aim to capture a larger sample size; the a priori power analysis discussed in chapter three called for a range of 21-325 participants per group. Given the time constraints, this study did not meet even the lowest threshold. It is recommended that additional studies recruit participants until there are at least 21 per group; however, as this study did not find a significant difference in methodology, it may be prudent to recruit beyond 325 participants to allow for attrition and to capture even a small effect size. Increasing the group sizes may also increase diversity within the groups to make the results more generalizable. To further increase diversity, a large multisite
study could be conducted to note any differences between geographical areas and/or cultural groups.

Future studies should move to an electronic or computer-based data collection method. Using electronic and/or online tools to collect data can decrease the time between its collection and analysis as the need to transcribe data is eliminated. This will also eliminate the possibility of data entry errors that can occur from entering data by hand. The design flaw noted in the paper-and-pencil collection method can be eliminated with an electronic version, although this platform likely also carries its own design caveats.

Recruiting a larger sample size and using an electronic survey method would also allow for changes in when the survey is administered. For this study, the pretest was administered immediately before and immediately after the intervention via paper-and-pencil to minimize attrition as the sample was already expected to be small. An electronic survey could be used to collect data at different intervals; for instance, at any time before and after the intervention rather than immediately before/after. This could also allow for longer term follow up if a researcher was interested in examining retention or long-term impact of the intervention. Recruiting a larger sample size can mitigate attrition.

Future studies should also consider adding open response questions to capture additional qualitative data and allow for thematic extraction. A mixed methods study could seek input from the participants as to how they felt about EOL care before and after the intervention. Other options could seek input regarding strength of presentation and barriers to learning, preferred learning style, and/or participant recommendations for improving the course.
It may also be prudent for a future study to examine the amount of time spent in simulation to determine if there is a dose effect – will spending more time in simulation have an impact on the results? In a modification of this study, the ELNEC core modules could be assigned as preparation for the simulation-based experience and all in-person learning dedicated to simulation and debriefing. If the simulation-based experience was found to be dose dependent, then it could be possible this study did not have a high enough dose to notice an impact. Examining for a dose effect could also help determine if there are diminishing returns when using simulation in EOL care instruction.

**Summary**

The results from this study indicate that simulation is as effective as face-to-face lecture alone in improving RN attitudes towards EOL care; there was no significant difference ($p = 0.879$) between the control and comparison groups’ mean difference in pretest-posttest scores. Many of the limitations of this study could be addressed by increasing the sample size and leveraging technology. A mixed methods study with thematic extraction could provide more context for changes in scores and may identify any confounding variables. It may also be prudent to examine the amount of time spent in simulation for a dose effect.
References


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http://www.aacnnursing.org/ELNEC/About


https://doi.org/10.1016/j.ecns.2009.07.003


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https://doi.org/10.17226/18748


https://doi.org/10.5480/14-1540


https://doi.org/10.1097/01.NND.0000433907.85137.2e


https://doi.org/10.1191/0269216304pm959oa


Hello Jonathan Benson,

Your application: *Examing instructional Methods in End-of-Life Nursing Education: Lecture vs. Simulation* is exempt from further review by the Institutional Review Board of South Dakota State University. Exemption is claimed under exemption criterion #2 outlined in 45 CFR 46, section 104(d).

Your consent form states that consent is implied by participating. The signature block is not required and should be removed.

Note: If the project is changed, it should be re-submitted to the IRB for a determination of whether it still satisfies exemption criteria.

Your approval number is: IRB-1902002-EXM. Please add this to your recruitment and consent material.

I wish you the best in your study.

Sincerely,

Dianne Nagy
Research Integrity and Compliance Officer
Appendix B: Sanford IRB Phased Approval

APPROVAL OF SUBMISSION

April 8, 2019

Dear Jonathan Benson:

The IRB reviewed the following submission:

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<td>Title of Study:</td>
<td>Examining Instructional Methods in End-of-Life Nursing Education: Lecture vs. Simulation; Examining Instructional Methods in End-of-Life Nursing Education: Lecture vs. Simulation</td>
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<tr>
<td>Investigator:</td>
<td>Jonathan Benson</td>
</tr>
<tr>
<td>IRB ID:</td>
<td>STUDY00001621</td>
</tr>
<tr>
<td>New Items This Review:</td>
<td>• Letter of agreement.pdf, Category: Other; • FATCOD-B tool.docx, Category: Survey; • Demographics.docx, Category: Data Collection Tool; • HRP-503e - TEMPLATE PROTOCOL Benson_2.docx, Category: IRB Protocol; • HRP-502a - TEMPLATE CONSENT DOCUMENT Minimal Risk (19).pdf, Category: Consent Form; • Recruitment flyer.pdf, Category: Recruitment Materials</td>
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<td>Special Determinations:</td>
<td>Waiver of consent documentation</td>
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</table>

The IRB approved the study in its current form on 4/8/2019 to 4/7/2020 inclusive. Before 4/7/2020 or within 30 days of study close, whichever is earlier, you are to submit a completed continuing review and required attachments to request continuing approval or closure. You can submit a continuing review by navigating to the active study and clicking Create Modification / CR.

If continuing review approval is not granted before the expiration date of 4/7/2020, approval of this study expires on that date.

All documents previously approved by the IRB remain approved until modified or withdrawn. If this study is closed to accrual, a new consent is not approved unless required for re-consent.

In conducting this study, you are required to follow the requirements listed in the Investigator Manual (HRP-103) and all policies relevant to human research, which can be found by navigating to the eIRB library. For questions please contact the IRB Office: eIRB@sanfordhealth.org.
APPROVAL OF SUBMISSION

August 19, 2019

Dear Jonathan Benson:

The IRB reviewed the following submission:

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<td>Investigator:</td>
<td>Jonathan Benson</td>
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<td>New Items This Review:</td>
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<td>• Simulation Script, Category: Other;</td>
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<tr>
<td></td>
<td>• ELNEC Training Agenda, Category: Other;</td>
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<tr>
<td>Special Determinations:</td>
<td>Waiver of consent documentation</td>
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</table>

The IRB approved the study in its current form on 8/19/2019 to 4/7/2020 inclusive. Before 4/7/2020 or within 30 days of study close, whichever is earlier, you are to submit a completed continuing review and required attachments to request continuing approval or closure. You can submit a continuing review by navigating to the active study and clicking Create Modification / CR.

If continuing review approval is not granted before the expiration date of 4/7/2020, approval of this study expires on that date.

All documents previously approved by the IRB remain approved until modified or withdrawn. If this study is closed to accrual, a new consent is not approved unless required for re-consent.

In conducting this study, you are required to follow the requirements listed in the Investigator Manual (HRP-103) and all policies relevant to human research, which can be found by navigating to the eIRB library.

For questions please contact the IRB Office: eIRB@sanfordhealth.org.
APPROVAL OF SUBMISSION

March 12, 2020

Dear Jonathan Benson:

The IRB reviewed the following submission:

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<td>Examining Instructional Methods in End-of-Life Nursing Education: Lecture vs. Simulation: Examining Instructional Methods in End-of-Life Nursing Education: Lecture vs. Simulation</td>
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<tr>
<td>Investigator:</td>
<td>Jonathan Benson</td>
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<td>IRB ID:</td>
<td>CR00001170</td>
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<tr>
<td>New Items This Review:</td>
<td>None</td>
</tr>
<tr>
<td>Special Determinations:</td>
<td>Waiver of consent documentation</td>
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The IRB approved the study in its current form on 3/12/2020 to 3/11/2021 inclusive. Before 3/11/2021 or within 30 days of study close, whichever is earlier, you are to submit a completed continuing review and required attachments to request continuing approval or closure. You can submit a continuing review by navigating to the active study and clicking Create Modification / CR.

If continuing review approval is not granted before the expiration date of 3/11/2021, approval of this study expires on that date.

All documents previously approved by the IRB remain approved until modified or withdrawn. If this study is closed to accrual, a new consent is not approved unless required for re-consent.

In conducting this study, you are required to follow the requirements listed in the Investigator Manual (HRP-103) and all policies relevant to human research, which can be found by navigating to the eIRB library.

For questions please contact the IRB Office: eIRB@sanfordhealth.org.
Appendix C: Recruitment Flyer

Dear Nurse:

You are invited to participate in a nursing research study aimed at evaluating differing educational methods. This is being conducted as partial fulfillment of the requirements for a Master of Science degree with an emphasis on nursing education from South Dakota State University. This study has been reviewed by the SDSU Human Subjects Committee, Sanford USD Medical Center Institutional Review Board, and Sanford USD Medical Center Nursing Research Committee. Your participation in this study is completely voluntary. There may be some risk from being in this study. Some risks are unknown at this time and some risks are small; for example, the risk of a breach of confidentiality. Your participation in this study will provide valuable feedback to determine effective methods for future continuing education activities. You have the right to terminate your participation in this study at any time. Data from this study will be self-coded by the participant to their mother’s maiden name and last 3 digits of their phone number. If you choose to participate, please help yourself to the refreshments provided and continue to the consent form that starts on the next page. If you choose not to participate, please still help yourself to refreshments and return this packet to your instructor. If you have any questions regarding this study, please do not hesitate to contact me using the information below.

Thank you

Jonathan Benson BSN, RN, RN-BC, CMSRN
SDSU Masters student
(605) 268-0546
jmbenson3324@jacks.sdstate.edu

SDSU IRB #: IRB-1902002-EXM
Appendix D: Demographic Questionnaire

Thank you for your willingness to participate in this study

Gender you most closely identify with (please circle one):

Male          Female          Prefer not to disclose

Age: ______    Years of Nursing Experience: ______

Highest degree obtained (i.e. diploma, associate’s, BSN) ___________________________

Ethnicity (please mark only one):

___American Indian or Alaskan Native      ___Asian
___Black or African American              ___Hispanic or Latino
___Native Hawaiian or Pacific Islander    ___White
___Prefer not to disclose

Nursing Specialty (i.e. oncology, ICU, hospice) ___________________________

Have you provided End-of-Life care prior to this class?    Yes          No

Have you had any prior formal End-of-Life education?    Yes          No

If yes, please explain and list approximate date (i.e. other continuing education - 2014, class in nursing school - 2008, etc.)
Appendix E: ELNEC Agenda

Agenda
ELNEC RN Training
4/11/19 or 4/25/19 ~ 0730-1630 ~ CLI

0730-0800  Registration / Welcome
0800-0900  Palliative & Hospice Nursing Care
           Renee Quanbeck, RN-BC & Kristina Sayler, BSN, RN
0900-1030  Pain Management
           Renee Quanbeck, RN-BC & Kristina Sayler, BSN, RN
1030-1045  Stretch Break
1045-1145  Loss, Grief, Bereavement & Self Care
           Sandra Reinesch, RN, CHPN
1145-1230  Lunch
1230-1350  Communication
           Sandy Young, RN, MS, CNS, BC, ACHPN
1350-1405  Stretch Break
1405-1530  Symptom Management
           Sandra Reinesch, RN, CHPN & Sandy Young, RN, MS, CNS, BC, ACHPN
1530-1630  Final Hours
           Kristina Sayler, BSN, RN
1630      Evaluation
Appendix F: ELNEC with Simulation Agenda

# Agenda
ELNEC RN Training
9/18/19 or 9/25/19 ~ 0715-1545 ~ CLI

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<tr>
<th>Time</th>
<th>Topic</th>
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<tr>
<td>0715-0730</td>
<td>Registration / Welcome</td>
</tr>
<tr>
<td>0730-0800</td>
<td>Palliative &amp; Hospice Nursing Care</td>
</tr>
<tr>
<td></td>
<td>Renee Quanbeck, RN-BC &amp; Kristina Sayler, BSN, RN</td>
</tr>
<tr>
<td>0800-0845</td>
<td>Pain Management</td>
</tr>
<tr>
<td></td>
<td>Renee Quanbeck, RN-BC &amp; Kristina Sayler, BSN, RN</td>
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<tr>
<td>0845-0900</td>
<td>Stretch Break</td>
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<tr>
<td>0900-0930</td>
<td>Loss, Grief, Bereavement &amp; Self Care</td>
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<tr>
<td></td>
<td>Sandra Reinesch, RN, CHPN</td>
</tr>
<tr>
<td>0930-1000</td>
<td>Communication</td>
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<tr>
<td></td>
<td>Sandy Young, RN, MS, CNS, BC, ACHPN</td>
</tr>
<tr>
<td>1000-1015</td>
<td>Stretch Break</td>
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<tr>
<td>1015-1100</td>
<td>Symptom Management</td>
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<tr>
<td></td>
<td>Sandra Reinesch, RN, CHPN &amp; Sandy Young, RN, MS, CNS, BC, ACHPN</td>
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<tr>
<td>1100-1200</td>
<td>Lunch</td>
</tr>
<tr>
<td>1200-1315</td>
<td>Simulation Exercise 1:</td>
</tr>
<tr>
<td></td>
<td>When/how to discuss Palliative Care with your patient</td>
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<tr>
<td></td>
<td>Jon Benson, RN, Renee Quanbeck, RN-BC &amp; Kristina Sayler, BSN, RN</td>
</tr>
<tr>
<td>1315-1415</td>
<td>Simulation Exercise 2:</td>
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<tr>
<td></td>
<td>Administering meds for symptom management with dying patient</td>
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<tr>
<td></td>
<td>Jon Benson, RN, Renee Quanbeck, RN-BC &amp; Kristina Sayler, BSN, RN</td>
</tr>
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<td>1415-1530</td>
<td>Simulation Exercise 3:</td>
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<tr>
<td></td>
<td>Care of the patient after death</td>
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<td></td>
<td>Jon Benson, RN, Renee Quanbeck, RN-BC &amp; Kristina Sayler, BSN, RN</td>
</tr>
<tr>
<td>1530-1545</td>
<td>Evaluation</td>
</tr>
</tbody>
</table>
Appendix G: Simulation Documents

Simulation Template
Sanford Health

Course Name/Content: ELNEC unfolding scenario

Author: Jonathan M. Benson
Date Created:

Client Name: Martha Banshee
Client Acuity:

Contributing Factors:
Mental Health:

Socio-Economic Factors:
Skills Needed:

Participant Assignments: (1) RN1 (2) RN2 or UAP

Actors: family member

Goals: By the end of ELNEC simulation learners will be able to properly use end-of-life order set, articulate the role of palliative care, use medications for adequate symptom management, and discuss process of postmortem care.

Objectives: (1) Use ordered pain medication to control patient’s pain

   (2) Discuss with patient/family purpose of palliative care and its benefits.

   (3) Recognize need for further symptom management

   (4) Provide peri-mortem while communicating with family

Participant Prep Needed: Attend morning ELNEC session
Participant Information Sheet

Client Name: Martha Banshee  
Age: 80  
DOB: 09/15/39

Physician: Dr. Lamfers

Client History/Problem:  
Mrs. Banshee is an 83-year-old female who presents to the ED today for intractable lower back pain, 10/10 in severity. CT shows extensive metastases in her sacrum and lumbar vertebrae, as well as progression of her colon cancer. She is being admitted for pain control and to meet with palliative care. This is her 5th hospitalization in the last month. She received 2 mg of morphine and that helped the pain some, the hospitalist is seeing her now. Her daughter is here with her now and plans to come up to the floor.

Medical History:  
Atrial fibrillation, Chronic obstructive pulmonary disorder, Chronic kidney disease stage III, Coronary artery disease, Colon cancer, Diabetes mellitus Type II, Gastroesophageal reflux disease, Heart failure, Hypertension

Allergies: Fentanyl, shellfish  
Height: 5ft 7in  
Weight: 125 lbs

Current Medications:  
40 mg oxycontin every 12 hours, 5-10 mg oxy IR every 3 hours as need for pain (takes about 6/day)

Vitals Signs – BP: 150s/90s  
HR: 90-100’s  
RR: 18-22  
Temp: 98.4  
SpO2: 90s on RA

Current Lines/Fluids/Drips: Right forearm, normal saline at 75 ml/hr. Port on the left but is not accessed

Current Orders:  
Morphine 2-4 mg every hour as needed for pain. Zofran 4mg every 4 hours as needed for nausea, vomiting.

Sim 2 – new meds:  
Morphine 2-8 mg every 10 minutes as needed for pain, dyspnea, air hunger. Morphine 1 mg/ml 55 ml syringe 0.5-10 ml/hr continuous infusion. Titrate every 1 hour as needed to relieve air hunger/dyspnea/severe pain. Haldol 0.5-2mg every 4 hours as needed for agitation, anxiety. Ativan 0.5-2mg every 2 hours as needed for restlessness, agitation

Additional Items from Report:  
Patient has been ambulatory at home without assistance, but pain currently makes this difficult.
Sim 2 – it is the next day and pain is slightly better but continues to be an issue. Due to a staff emergency a nurse had to leave and you are getting report from the CCL. “has a history of metastatic colon cancer and was admitted yesterday for pain control and PC consult. They decided to pursue a comfort pathway. Morphine was used multiple times overnight.

Sim 3 – it is the following day and the morphine drip is now at 6 mg/hr. Boluses needed occasionally and with repositioning. Ativan has been given several times.
**Scenario Set-Up**

**Initial Computer Set-Up:**

BP 150s/90s  HR 90-100s  RR low 20s  Temp 98.4  SpO2 96

Lungs: Lt. clear  Rt. clear  Heart: S1S2, no murmur  Rhythm: regular

Bowel Sounds: Active x4  Eye Opening: spontaneous

Other: safe zone square taped off by computer, clock covered. Sim 2 – document morphine pushes on MAR. Sim 3 – low lighting, comfort channel type music on the TV

**Equipment Needed**

**Modality of Simulation:** Manikin

**Which Manikin:** Sim man 3g  Non-medical Props:

**Gender:** female  **Dress:** wig/head wrap  **Wounds:**

**Foley/Volume in bag:**  **PCA Pump/Med:** morphine 1 mg/ml for 2nd sim

**Peripheral IV:** R Forearm  **Epidural Pump/Med:**

**IV Pump/fluid/rate:** NS @ 75  **Suction:**

**CVAD:** Port on left (not accessed)  **Blood Product/rate:**

**Tubes/Drains:**  **Dressings:**

**Where do you want your patient? (bed, floor, chair, couch, etc.)**

Bed – low position, side rails up x2

**Other Equipment (SCD’s, Teds, Med Cart, Gait Belt, W/C, etc.):** Eyeglasses, high back chair, oxygen flow meter, nasal cannula, med cart
<table>
<thead>
<tr>
<th>Timing</th>
<th>Control Room</th>
<th>Expectations</th>
<th>Cues/Scripting</th>
</tr>
</thead>
<tbody>
<tr>
<td>10-15 minutes</td>
<td>HR: 90-100s RR: low 20s, Temp: 98.4 BP: 150s/90s, Patient moaning, reporting low back pain 10/10. With medication: pain decreases to 8/10, vitals remain elevated</td>
<td>Administer pain medications for symptom control</td>
<td>Family member: Inquire about pain medications when patient moans or reports pain. After pain medication has been given you think patient is still in a lot of pain, ask if there is anything else they can do</td>
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<tr>
<td></td>
<td>Call into room: Dr. Lamfers – How is his pain? I spoke with Dr. Person-Henry from palliative care and she is planning to come up and meet at 1:30. Can you let them know?</td>
<td>Discuss what palliative care is</td>
<td>Family member: After further pain interventions: ask about palliative care, “the Dr. in the ER mentioned something about the palliative care team what do they do? What is palliative care? Is that like hospice?</td>
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<tr>
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<td></td>
<td>Inform patient of palliative care meeting</td>
<td>Family member: that sounds good. We have other family members on the way that should be here by then. Thank you.</td>
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<td></td>
<td>Patient then requests glass of water or other intervention to allow learners to exit the room and end scenario</td>
</tr>
<tr>
<td>Time</td>
<td>HR, RR, Temp, BP, Patient's Condition</td>
<td>Care Action</td>
<td>Family Member's Concerns</td>
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<tr>
<td>-------------</td>
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<tr>
<td>15-20 min.</td>
<td>HR: 100s, RR: 20s, Temp: 99.3 BP: 150s/90s, Patient reporting low back pain 8/10</td>
<td>Recognize need for further pain management</td>
<td>Family member: can we do anything more for her pain? The nurses last night were in here sometimes 3 times an hour. The palliative care dr. said something about a drip?</td>
</tr>
<tr>
<td></td>
<td>After drip has been started: HR: 90s, RR 8, BP 130s/80s, pain now 6/10</td>
<td>Initiate continuous pain medication infusion and bolus dosing</td>
<td>Family member: Will this be better for her? Can she still get more medication if he needs it. I don’t want her to get addicted. Will she still be able to talk to me? Is it ok that she is breathing that slow? Can she still hear me?</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Discuss patient’s condition with family</td>
<td>Ask for glass of water/cue learners ok to leave and end sim</td>
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<tr>
<td>10-15 min.</td>
<td>HR: 120s, RR: 30s, temp: 101.3, BP: 90s/40s, patient unresponsive</td>
<td>Recognize nonverbal signs of pain</td>
<td>Family member: she has been grimacing a lot more. Is it normal to breathe that fast? Her heart rate seems really high, does that mean he’s in pain?</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Perform death assessment</td>
<td>Family member: is she gone?</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Comfort/educate family</td>
<td>Did we make the right choice giving her pain medicine? What now? Is there a chaplain?</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Call chaplain</td>
<td>Give leaners ok to call/page a chaplain and end sim</td>
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Appendix H: Simulation Debriefing Guide

Debriefing Guide (1)

Tanner Stages:

(Noticing) – reports of pain

(Interpreting) – vital signs, metastases on CT

(Responding) – giving medication

(Reflecting) – reassess pain, consider different options

Debriefing Priorities: how do you feel?

(1) palliative care vs hospice

(2) pain management

(3) Body language/self-awareness

(4) practicing what to say

Observation Notes:
Debriefing Guide (2)

Tanner Stages:

(Noticing) – continues to report pain

(Interpreting) – need for more aggressive symptom management, active listening to family questions

(Responding) – giving medication, starting drip, answering family questions

(Reflecting) – reassess symptoms, try additional interventions

Debriefing Priorities:

(1) when to give more/different medications, when to start drip

(2) respiratory depression and supplemental oxygen

(3) opioid “addiction” at end-of-life

(4) environment

Observation Notes:
Debriefing Guide (3)

Tanner Stages:

(Noticing) – increased vitals, decreasing respirations,

(Interpreting) – need for additional medication base on observations, expiration of patient

(Responding) – giving medication, perform death assessment, offer chaplain services

(Reflecting) – reassess, consider different options

Debriefing Priorities: how do you feel now?

(1) “last dose”

(2) symptom management

(3) family support

(4) self-care

Observation Notes:
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Expected presentation date: Oct 2020
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**Instructor name**
Dr. Horsley

**Institution name**
South Dakota State University

**Expected presentation date**
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Appendix J: FATCOD-B

In these items, the purpose is to learn how nonfamily caregivers feel about certain situations in which they are involved with patients. All statements concern the giving of care to the dying person and/or his/her family. Where there is reference to a dying patient, assume it to refer to a person who is considered to be terminally ill and to have six months or less to live.

*Nonfamily caregiver is defined as anyone who is giving care to the dying person, professional or nonprofessional, who is not a member of the patient’s family.

Please circle the statement that corresponds to your own personal feelings about the attitude or situation presented.

Please respond to all 30 statements on the scale.

1. Giving care to the dying person is a worthwhile experience.
   Strongly disagree  Disagree  Uncertain  Agree  Strongly agree

2. Death is not the worst thing that can happen to a person.
   Strongly disagree  Disagree  Uncertain  Agree  Strongly agree

3. I would be uncomfortable talking about impending death with the dying person.
   Strongly disagree  Disagree  Uncertain  Agree  Strongly agree

4. Caring for the patient’s family should continue throughout the period of grief and bereavement.
   Strongly disagree  Disagree  Uncertain  Agree  Strongly agree

5. I would not want to care for a dying person.
   Strongly disagree  Disagree  Uncertain  Agree  Strongly agree

6. The nonfamily caregivers should not be the one to talk about death with the dying person.
   Strongly disagree  Disagree  Uncertain  Agree  Strongly agree

7. The length of time required giving care to a dying person would frustrate me.
   Strongly disagree  Disagree  Uncertain  Agree  Strongly agree

8. I would be upset when the dying person I was caring for gave up hope of getting better.
   Strongly disagree  Disagree  Uncertain  Agree  Strongly agree

9. It is difficult to form a close relationship with the dying person.
   Strongly disagree  Disagree  Uncertain  Agree  Strongly agree
10. There are times when the dying person welcomes death.
   Strongly disagree  Disagree  Uncertain  Agree  Strongly agree

11. When a patient asks, “Am I dying?” I think it is best to change the subject to something cheerful.
   Strongly disagree  Disagree  Uncertain  Agree  Strongly agree

12. The family should be involved in the physical care of the dying person.
   Strongly disagree  Disagree  Uncertain  Agree  Strongly agree

13. I would hope the person I’m caring for dies when I am not present.
   Strongly disagree  Disagree  Uncertain  Agree  Strongly agree

14. I am afraid to become friends with a dying person.
   Strongly disagree  Disagree  Uncertain  Agree  Strongly agree

15. I would feel like running away when the person actually died.
   Strongly disagree  Disagree  Uncertain  Agree  Strongly agree

16. Families need emotional support to accept the behavior changes of the dying person.
   Strongly disagree  Disagree  Uncertain  Agree  Strongly agree

17. As a patient nears death, the nonfamily caregiver should withdraw from his/her involvement with the patient.
   Strongly disagree  Disagree  Uncertain  Agree  Strongly agree

18. Families should be concerned about helping their dying member make the best of his/her remaining life.
   Strongly disagree  Disagree  Uncertain  Agree  Strongly agree

19. The dying person should not be allowed to make decisions about his/her physical care.
   Strongly disagree  Disagree  Uncertain  Agree  Strongly agree

20. Families should maintain as normal an environment as possible for their dying member.
   Strongly disagree  Disagree  Uncertain  Agree  Strongly agree

21. It is beneficial for the dying person to verbalize his/her feelings.
   Strongly disagree  Disagree  Uncertain  Agree  Strongly agree

22. Care should extend to the family of the dying person.
   Strongly disagree  Disagree  Uncertain  Agree  Strongly agree
23. Caregivers should permit dying persons to have flexible visiting schedules.
Strongly disagree  Disagree  Uncertain  Agree  Strongly agree

24. The dying person and his/her family should be the in-charge decision-makers.
Strongly disagree  Disagree  Uncertain  Agree  Strongly agree

25. Addiction to pain relieving medication should not be a concern when dealing with a dying person.
Strongly disagree  Disagree  Uncertain  Agree  Strongly agree

26. I would be uncomfortable if I entered the room of a terminally ill person and found him/her crying.
Strongly disagree  Disagree  Uncertain  Agree  Strongly agree

27. Dying persons should be given honest answers about their condition.
Strongly disagree  Disagree  Uncertain  Agree  Strongly agree

28. Educating families about death and dying is not a nonfamily caregiver responsibility.
Strongly disagree  Disagree  Uncertain  Agree  Strongly agree

29. Family members who stay close to a dying person often interfere with the professional’s job with the patient.
Strongly disagree  Disagree  Uncertain  Agree  Strongly agree

30. It is possible for nonfamily caregivers to help patients prepare for death.
Strongly disagree  Disagree  Uncertain  Agree  Strongly agree