Nursing students' perception on transferring experiences in palliative care simulation to practice

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A B S T R A C T

Background: Learning palliative care is challenging for nursing students. Simulation is recommended as a learning approach. Whether experiences from simulation transfer into clinical practice must be investigated.
Objective: The aim of this study was to explore nursing students' experiences of participating in palliative care simulation and examine how they describe the perceived transfer of knowledge, skills, and competence into clinical practise.
Method: This prospective, qualitative study was comprised of 11 in-depth interviews with second-year bachelor nursing students. Content analysis was performed to analyse the answers to open-ended questions.
Results: From this sample, simulation is a preferred method to gather knowledge, skills, and attitudes towards palliative care. Realistic cases stimulated senses and feelings. Courage grew through active participation and debriefing and influenced the students' self-confidence. Debriefing seemed to alter the situation from one of chaos to control.
Conclusions: Experiences from the simulation were perceived to transfer to practice, serve as a sound basis for clinical judgement, and enable communication with patients and their relatives. Continuity in learning through simulation combined with practice is highlighted.

1. Introduction

Palliative care promotes quality of life for seriously ill and dying patients through symptom control and other mental, social, or existential challenges for the patients and their relatives. An ageing population, with more complex chronic and life-limiting conditions, will increase the demand for competence in the field. At present only approximately 14% of people worldwide who need palliative care currently receive it. Lack of education and training, and awareness of palliative care among health professionals are major barriers to improving access (Worldwide Palliative Care Alliance/WHO, 2014). Since nurses are frontline care providers, an important field for nursing education is palliative care, including end of life care. To achieve the aim of palliative care, students must learn about symptom management and how to care for and communicate in order to enhance the patients' and their families' quality of life (Gamondi et al., 2013). However, nursing students find palliative care challenging to learn and perform (Hall-Lord et al., 2017; Henoch et al., 2017) and feel unprepared for palliative care in clinical practice (Alt-Gehrman, 2017; Hall-Lord et al., 2017; Henoch et al., 2017). A literature search by Gillan et al. (2014b)

found that palliative care is poorly addressed in nursing curricula and is traditionally presented in lectures and group discussions. Although students benefit from different teaching strategies (Alt-Gehrman, 2017; Venkatasalu et al., 2015), in this field, reflection on competence and their own reactions to death is warranted (Gillan et al., 2014b; Henoch et al., 2017). Reflection is emphasised as a cornerstone for learning in simulation-based education (Decker et al., 2013; Fanning and Gaba, 2007; Husebø et al., 2015), and simulation is recommended as an active learning approach to prepare students for palliative care (Kirkpatrick et al., 2017; Smith et al., 2018; Venkatasalu et al., 2015).

2. Background

Jeffries (2005, p. 97) defines simulation as "activities that mimic a clinical environment where you can train procedures, decision-making and conduct critical thinking using role play, games, video or simulators." Characteristics of the learning method include learning objectives, fidelity, problem solving, support, and debriefing whereupon the situation and learning outcomes are reflected on (Jeffries, 2012). Three domains of learning are involved. Knowledge was primarily described

by Bloom et al. (1956). The affective or emotional domain, which is a further development in the domain of knowledge, was elucidated by Krathwohl et al. (1964). The psychomotor domain was described by Harrow (1972). Simulation allows participants to combine these domains through theoretical knowledge, practical skills, and emotions, and integrate them into the value-base of nursing in a risk-free environment (Campbell and Daley, 2017). However, it might be challenging to integrate all three domains because they have their own taxonomies where participants can be at different levels. The use of the three domains of learning in simulation can be described as experiential learning and gives the participants an opportunity to go through the stages of Kolb's experiential learning cycle in a structured manner (Fanning and Gaba, 2007). Kolb's experiential learning cycle contains four related parts: concrete experience, reflective observation, abstract conceptualisation, and active experimentation (Kolb, 2015). In simulation, the concrete exercise is combined with debriefing with the intent to provide an analysis of and reflection on the experience, aiming to facilitate new experiences (Fanning and Gaba, 2007). Simulation is often used in advanced medical, surgical, obstetric, and paediatric courses (Hayden et al., 2014) but less so in palliative care (Kirkpatrick et al., 2017). Students who have simulated cases with a palliative focus report increased confidence, improved communication skills, and learned palliative care principles. A change in attitude from wanting to cure the patient to simply being present and focusing on quality of life is difficult although recognised as essential (Kirkpatrick et al., 2017). When family members are included in scenarios, complexity increases and greatly influences students' learning. However, few studies include this perspective (Alt-Gehrman, 2017; Kirkpatrick et al., 2017). Identifying gaps in the literature and providing directions for future research is how students transfer learning outcomes from simulation into clinical practice (Kirkpatrick et al., 2017; Smith et al., 2018; Stroup, 2014; Venkatasalu et al., 2015).

According to Mezirow (1991), transformative learning focuses on "the process of using a prior interpretation to construe a new or received interpretation of one's experience in order to guide future tasks." There is a need to investigate if simulation gives nursing students knowledge and awareness needed to increase the access to palliative care for seriously ill patients and their families.

3. Aim

The aim of this study was to explore nursing students' experiences of participating in a palliative care simulation and examine how they describe the perceived transfer of knowledge, skills, and competence into clinical practise.

4. Methods

4.1. Design

A qualitative explorative design (Polit and Beck, 2014) was used to increase the understanding of nursing students' experience with palliative care simulation and the transfer of knowledge, skills, and competence into practice.

4.2. Setting

During the spring 2017, a university in Norway conducted a three-hour simulation activity addressing palliative care. The simulation was held at the beginning of the second year nursing students' eight weeks of hospital practice. In Norway, nursing education offer bachelor-level programs that last for three years. The duration of the clinical training is one-half of the education (Lahtinen et al., 2013).

The simulation design was based on the International Nursing Association for Clinical Simulation and Learning standards of best practise simulation (INACSL Standards Committee, 2016). Learning

Table 1
Description of the simulation cases and learning outcomes used in this study.

Simulation case and learning outcome
Patient: Jesper Jensen, 69 years old. Metastatic lung cancer. Hospitalized with poor general condition, pneumonia and pain. Treated with antibiotics and analgesics. No longer interested in food. Informed by the doctor of short life expectancy.
Case 1: Relational skills.
The students simulate that the nurse is taking away the antibiotic infusion, and offer the patient some food. Jensen is tired. He has realized that he is going to die soon, and is no longer interested in eating. Jensen's wife has a different view of the situation and requests tube feeding for her husband. A teacher act as standardized patient.
Learning outcome
Knowledge: knowledge of nutrition, relevant to the dying patient and relatives.
Skills: communicates about the patient's situation with patient and relatives. Safeguards patient and wife's autonomy and integrity according to ethical and legal guidelines.
General competence: show respect, understanding and take other people's situation and experience seriously.
Case 2: Clinical assessment.
This case focused on clinical assessment when Jensen is diagnosed as terminal. The wife is present. A High Fidelity Simulator is used.
Learning outcome
Knowledge: observe and evaluate clinical signs of a dying patient using the Edmonton Symptom Assessment System (ESAS).
Skills: initiate symptomatic relief in a dying patient.
General competence: ensure the dying patient and his relative's integrity and dignity in accordance with ethical and legal guidelines.

outcomes were in line with core competence in palliative care (O'Connor, 2016; Gamondi et al., 2013). The cases (see Table 1) were developed based on two focus-group interviews, one with third-year students and one with supervisors in practise, to strengthen the relevance of the cases. Students from different medical and surgical wards were invited to this voluntarily simulation to ensure a sufficient number of participants. The simulation at the university included 55 participants who were divided into groups of six students who switched between being three observers and three in action during the simulation. The same participants conducted each case twice. The use of a briefing and debriefing guide ensured similarities in the different groups. The participants were familiar with simulation as a learning approach, as it is a method used in their education. The facilitators were trained by the Copenhagen Academy of Medical Simulation and had between five and 10 years of experience in simulation pedagogy.

4.3. Recruitment

Recruitment for the in-depth interviews occurred during the students' last week of hospital practice. To avoid first-hand contact between the researchers and respondents (WMA, 2013), supervisors in the wards identified relevant candidates and informed the first author. The students were contacted via email.

4.4. Participants

This study comprises 11 s-year bachelor nursing students (Table 2). Inclusion criteria included participation in palliative care simulation during their second or third practise period. They should have gained experience in palliative care during that particular practise, representing different genders and from various medical or surgical wards. Exclusion criteria included students with substantial former palliative care experience.

4.5. Data collection

The first author (KV), who is a palliative care specialist and educator, had taught the students in a previous course but was not involved in this semester. Data collection was conducted in a group room at the

Table 2
Description of the participants`.

Participants.	Gender.	Second year students. Practice period 2 or 3.	Former experience with palliative care.
Informer 1	Female	Practice 2 Medical unit	No former experience
Informer 2	Female	Practice 2 Medical unit	No former experience
Informer 3	Female	Practice 2 Surgical unit	Refers to one former experience
Informer 4	Female	Practice 2 Surgical unit	Some former experience
Informer 5	Female	Practice 2 Medical unit	No former experience
Informer 6	Female	Practice 2 Surgical unit	Some former experience
Informer 7	Female	Practice 3 Surgical unit	One former experience
Informer 8	Male	Practice 2 Surgical unit	No former experience
Informer 9	Male	Practice 3 Surgical unit	Some former experience
Informer 10	Female	Practice 3 Medical unit	Some former experience from practice
Informer 11	Female	Practice 3 Medical unit	Some former experience from practice

university. The interviews were audio-recorded. The other researchers came from different departments or universities and were unknown to the students. The research group developed a semi-structured interview guide based on the research question *"What do nursing students describe as their experiences from simulation of palliative cases, and what are their perceptions of the transition of knowledge, skills, and competence from simulation into practise?"*

One-by-one interviews were used to explore the participants' personal experiences.

4.6. Data analysis

The first author (KV) transcribed the audio-recorded interviews verbatim. The last author (EKG) checked every third transcript against the audio recordings. This study used content analysis inspired by Graneheim and Lundman (2004) and Graneheim et al. (2017) to analyse answers to the open-ended questions. The first step, exploring the interview text, was conducted by the first author who read the text several times with an inductive approach to obtain the overall meaning and identify meaningful units. Without reducing the core, the meaning units were coded by the authors (KV, ALH, KTJ, and EKG), who then discussed how the units could be understood and interpreted (Graneheim and Lundman, 2004; Graneheim et al., 2017). To enhance the study's credibility and confirmability (Lincoln and Guba, 1985), all of the authors discussed the analytic steps to ensure agreement on a main theme, themes, and categories (Table 3). The researchers' significant experience as nurses might have influenced their interpretations of the meaning units or quotations.

4.7. Ethical considerations

The participants were informed both in writing and orally about the study purpose, that it was voluntarily, they had a right to withdraw, and that their grades in practise would not be affected. Furthermore, their data would be treated confidentially (World Medical Association, 2013), and the study would be conducted in accordance with the ethical guidelines for nursing research in the Nordic countries

(Northern Nurses Federation, 2003). All of the participants provided written consent. The simulation team discussed and took into account that the participants might feel uncomfortable both in relation to palliative care and the simulation. To avoid the possibility that their roles as both facilitators and interviewers might affect the interviews, the authors of this article were not facilitators of the simulation.

5. Findings

The following themes were identified from the analysis: (1) train as you fight; (2) from chaos to control; (3) and perceived transfer to practise (Table 3). A more latent theme emerged through the themes and categories. The participants reported that they needed to leave their comfort zones to participate in the simulation and debriefing. It sometimes felt like an assessment. This was interpreted as challenging their courage. However, a safe learning environment, new insights, and confidence received during the simulation and debriefing was described to make the participants feel safer and more self-confident when making relationships and clinical judgements in practise. The authors perceived that this increased the participants' courage. An overarching theme was therefore interpreted as the courage to dare.

5.1. Train as you fight

According to the participants, the simulation was more educational than lessons or self-study. *"I say 'train as you fight.' You can have many lessens but by visualising and physically acting, it will be a reflex reaction when you get into practise"* (9). This was explained as *"It's easier to learn things practically as you'll remember the cases when you learn things in a different way"* (4). They especially drew attention to their simulation experiences by applying their senses and feelings. They experienced how body language influenced communication and the value of keeping calm. *"I have not previously had a visual experience on the importance of keeping calm and not panicking. In the second round, the nurses were much calmer and then the patient became calmer"* (2). One case focused on common signs in a dying patient and provided the participants' with experiences on clinical changes. *"It's easier to remember when I can feel how you look for signs, when I can take the hand and feel the skin"* (7). Some found it more logical to understand when they heard respiratory changes, explanations, and feedback.

The participants described palliative care and simulation as an "out of the comfort zone experience" that activated their emotions. *"At first I didn't want to, but one is supposed to get out of one's comfort zone, and it's OK to have these kind of experience before you become a nurse"* (1). Simulation was perceived as scary, and for some unnatural, especially those who simulated with manikins. They needed to release their control, in the simulation and debriefing, and expressed that *"It is not a good feeling to lose face in front of fellows if you do something really wrong"* (2). They emphasised that the simulation was less scary than real situations. Since they could not harm the patient, the simulation was described as a safe learning environment. *"If you are uncertain in practise, you leave the situation without the opportunity to gain insight into what would have been the right course of action"* (6). The opportunity to not harm, but test and discuss different alternatives, gave them opportunities to dare. *"Practise is very serious; the patient can die even in a learning situation. That can't happen in simulation. Therefore, we dare more"* (2).

Table 3
Example from the content analysis including themes and connecting categories.

Overarching theme	Courage to dare		
Theme	Train as you fight	From chaos to control	Perceived transfer to practice
Categories	Experiences through applying their senses and feelings.	Debriefing opens for new insights.	Safe and self-confident in practice.
	Out of the comfort zone.	Simulation as assessment.	Trained to make relations with patient and relatives.
	Safe environment for learning.	Debriefing gives self-confidence.	Trained to do clinical judgments.
			Experiences from simulation continues in practice.

They called attention to the facilitator's role in relieving the pressure on their performance anxiety. "The facilitator's allowed us to lower our shoulders and work without fear…. It made it much easier for us when we simulated the cases" (9).

5.2. From chaos to control

The participants said that their attitudes towards palliative care changed throughout the debriefing, and reflecting upon the situation helped them manage it in a new way. *"We felt a lack of control. The observers said that we were too busy with technical skills. Then we got many tips on how we could be more present. We tried this, and the situation became different"* (7). The opportunity to simulate twice was emphasised by the participants. Perceived knowledge, skills, and a new attitude changed the situation and were expressed as *"I felt we went from chaos to control"* (7). The participants agreed that reflecting on the simulated situation provided an opening for new insights. *"Debriefing is mind-expanding and a confirmation of one's knowledge that promotes a feeling of security. At the same time, you get new knowledge from others"* (5).

For some of the participants, simulation was described as an assessment, and debriefing as an examination. *"If it gets too much like an exanimation, I don't learn much"* (10). One described the simulation and debriefing as an assessment of future skills. *"They judge you from how good you will be in your profession"* (1). A better performance was experienced when the level of expectation was low. The power structure between the students and facilitator was interpreted as "*we are the kids in the room*" (2). The most preferred feedback came from the other students. *"It's good that the facilitator says something, but it's just as useful what the students say – we are more in agreement"* (5). The opportunity to participate and discuss feedback was emphasised. *"Debriefing is more than feedback, you get a discussion on the feedback and an opportunity to consider a better solution"* (2). The discussion focused on what they had managed and what they could improve. *"The facilitator does not break us down, but builds us up and tells us what is good and what we can do differently"* (7). *"While the students often say 'well done,' the facilitator says 'well done because,' and links it to theory"* (11).

5.3. Perceived transfer to practise

The palliative care simulation gave the participants perceived self-confidence to seek palliative care situations, establish good relationships, and use their clinical judgement. In their opinion, a feeling of self-confidence was created in the simulated setting and was a result of new knowledge regarding managing palliative care situations. *"Before the simulation, I withdrew, afterwards in practice I had more knowledge, felt secure and more self-confident to be in the situation and make choices. I recognised that my self-confidence transmitted to the patient and family and contributed to a relaxed atmosphere"* (9). The simulation made palliative care less scary. *"I think it was the simulation that made me dare to examine that patient … probably because I was safer than before"* (7). Some of the participants reflected that the opposite might have happened if they had not felt a sense of achievement from the simulation. *"I think the nervousness from the simulation could hold you back if you felt insecure and didn't manage. The sense of security created in simulation helps you in practise"* (10). Another participant was unaware of a connection. *"I'm not sure that I thought about what I'd learned in simulation when I was in practise, but I did remember that in simulation, I thought this was a good way to act"* (4).

The participants described how they used experiences from the simulation to be more present in their relationships with patients. They knew more about how to respond, expressed through relief and joy: *"The patient had hinted that she wanted to talk – I felt it was difficult to get into it – but after we had simulated and seen how much it could help, I let the patient talk – I dared to!"* (7). The participants reported that they had more self-confidence to respond to relatives' needs. *"The relatives looked at me, and I noticed that they expected that I would be scared. Nevertheless,*

I felt self-confident to talk to them about what they felt … without the simulation, I would have had more panic about how to talk to them" (10). One referred to this as courage. *"Actually, if I compare with earlier, I feel that I have a little more guts to talk to relatives"* (11). If the situation became too complicated, they stepped back. *"I avoided a situation. The patient was very young – he had many relatives present … there was a lot of fear and worries … I did not feel safe enough"* (7).

Clinical signs in a dying patient observed in simulation were recognised in practise and promoted the participants' clinical judgement. *"I was the first to recognise the patients' apnoea period. We had talked about it in simulation … so I thought hey, I have seen this before. We don't simulate just to feel ready, it built self-confidence to get a reality check of ones' knowledge"* (10). The simulation increased the students' awareness of what should be emphasised with a dying patient. *"I stood with the blood pressure gauge in my hand, the patient was dying. Then I thought, stop – what did we learn in simulation – the patient doesn't need to know what his blood pressure is – he needs to know that someone is present. So I put the blood pressure gauge away"* (7).

The participants were grateful for this consciousness-raising early in practise. *"Personally, I had great benefit from the simulation at the start of the practise period because I got the opportunity to use it and work on it"* (11). They underwent personal development and realized that they could contribute to palliative care situations in a new way. *"I think both as a person and a professional I can actually use this simulated experience"* (11).

6. Discussion

The aim of this study was to explore nursing students' experiences of participating in a palliative care simulation and examine how they described the perceived transfer of knowledge, skills, and competence into clinical practise. The interpreted overarching theme, courage to dare, provided a basis to discuss how the participants' use and receive courage to develop knowledge, skills, and competence in simulation, prerequisites for development to occur and transfer into practise.

Hawkins and Morse (2014, p.266) defines courage in nursing practise as "Despite fear for self and others, courage is ethical-moral "risk-taking" action with the intent to ensure safe patient care". They argue, that courage can be learned and mentored, and that a core attribute to courage is duty and responsibility, which manifests in advocacy (Hawkins and Morse, 2014). The participants in this study reported that testing and discussing different alternatives during the simulation was challenging. Corresponding to the findings of Kirkpatrick et al. (2017), they reported that, when taking the challenge, stress and anxiety decreased while their self-confidence increased concurrently with increased communication skills and a new attitude towards palliative care.

Observing palliative care situations in simulation using their senses combined with the opportunity to discuss the situations in debriefing, in line with Kolb's reflecting cycle (Kolb, 2015), was described as useful for recognising palliative care needs. This is in line with findings of Gillan et al. (2014a) that support the view that experimental learning by visualising and hands on experience combined with reflection in debriefing increases knowledge in palliative care. In our study the findings refer to simulation both as "out of the comfort zone" and a "safe learning environment." The participants said that they felt vulnerable and were afraid of losing control and reported that they needed to use courage to participate. They noted that if the simulation was too stressful, they did not learn much. However, acceptance of making mistakes, opportunities to simulate twice, and the facilitators' support were factors described as helpful for lowering their stress levels.

The participants described several prerequisites for the development of knowledge, skills, and competence in the simulation. Realistic training in a safe environment is in this study was referred to as "Train as you fight." This adage relies on a military expression for realistic training (Rietjens et al., 2013). Fight refers to the army, while in this

setting, the fight could be interpreted as the nursing performance. A safe learning environment combined with debriefing seems to increased self-confidence. Flannery and Grace (1999, p. 36) defines self-confidence as "courage to act derived from certainty about one's capabilities, values, and goals." It is characterised by belief in positive achievements, persistence, and self-awareness, and promoted by knowledge, experience, motivation, and success. The participants' description of "from chaos to control" refers to chaos in the room and chaotic feelings. Even if the situation is not real, the feelings are (Kirkpatrick et al., 2017). As previously described (Gillan et al., 2014a; Kirkpatrick et al., 2017), the participants in this study recognised through simulation that change of attitude from wanting to cure the patient to simply being present and focusing on quality of life is a core competence in palliative care. When using their knowledge, skills, and competence to be present, they experienced control. Palliative care became less frightening. This finding corresponded to results from Venkatasalu et al. (2015). A prerequisite to the feeling of changing chaos into control can be that the students and facilitator worked together in action and reflection. Reflection in debriefing is a cornerstone of simulation and promotes critical thinking (Decker et al., 2013; Stroup, 2014). The opportunity to confirm one's own knowledge and take part in others' perspectives seems to provide new insight. Adding the affective domain of learning in debriefing (Gibbs, 1988) increases engagement and learning (Husebø et al., 2015).

The present study describes a tension between debriefing that provides self-confidence and debriefing as assessment. The participants emphasised the value of having a discussion, not just feedback. Debriefing can create a potentially uncomfortable experience (Decker et al., 2013). Combined with the emotional intensity associated with palliative care, the way debriefing is implemented is of great importance for the learning outcome (Kirkpatrick et al., 2017).

According to Campbell and Daley (2017), the reflecting process in simulation leads to thoughts, actions, and learning outcomes for the better transfer of knowledge to practise and more nuanced thinking about future tasks. To foster transformative learning, the simulation cases require fidelity according to the equipment, environment, and psychological factors (Jeffries, 2012). A safe learning environment is needed (Clapper, 2010).

Regarding the perceived transfer to practise, the participants said that they used the simulation as a frame of reference to recognise clinical changes. They made clinical judgements and took action. Reflections on paradigm cases that include knowledge on how to manage situations is described as a way to identify practical knowledge that can translate to clinical settings (Benner, 2010; Valen et al., 2011). Findings from Venkatasalu et al. (2015) support the view that simulation prepares students to recall their learning in practise. Several participants in this study were uncertain how they could have managed palliative care situations without the simulation, but there are doubts. The translation of simulated experiences to practise is not necessarily a straightforward process (Nash and Harvey, 2017). One must consider the design, effective reflection through debriefing, the participants' experience with the method, and the opportunity to use the knowledge in practise.

From this sample, changed attitudes and increased self-confidence seemed to influence the perceived transition of knowledge, skills, and competence. The participants reported that they were more self-confident in palliative care situations than before the simulation. It seems like they use their courage to seek situations and pursue relationships with patients and relatives. Nursing students struggle with the presence of relatives (Henoch et al., 2017). Few studies deal with how students speak with family members (Kirkpatrick et al., 2017). This study indicates that the participants gained knowledge and courage to talk to relatives and supports recommendations to include relatives' perspective in palliative care education and simulation (Alt-Gehrman, 2017; Hall-Lord et al., 2017; Henoch et al., 2017).

The participants in the present study reflected on their increased self-confidence as a result of support from the group, and posited that the opposite might happen if their emotions were not adequately managed in the simulation. Gibbs (1988) states that learners can return to feelings of failure at a later stage when dealing with similar situations in practise. This emphasises the importance of education when supporting students in both palliative care simulations and in practise to reduce fear so courage can develop and the student can provide safe patient care. The findings of this study indicate that combining simulation and clinical practise can strengthen the learning process.

7. Strengths and limitations

The strengths of this study are user participation preparing realistic cases. The informants were familiar with simulation as a learning approach. Four facilitators experienced in simulation pedagogy used a briefing and debriefing guide to ensure similarities. The simulation was combined with hospital practise and reflecting the learning outcomes in terms of knowledge, skills, and competence in palliative care. The informants represented various hospital wards and different genders and had none or few previous experiences with palliative care. They all gained experience with palliative care situations during practise. The first author collected all of the data.

Since recruitment was voluntary, a limitation can be that students who dislike simulation and those not interested in palliative care might not be represented. We assumed that the use of a manikin, as mentioned by the students, can reduce realism in the simulation; however, others reported that the manikin represented a safe learning environment. The sample was collected at a single institution and the number of informants was low. The purpose of studies based on small samples is not to generalise but rather to gain in-depth knowledge and new hypotheses from participants (Lincoln and Guba, 1985).

8. Implications for future research and nursing education

The authors suggest further studies with different methodological approaches focusing on palliative care simulation. These can provide opportunities to evaluate the effect of the simulation, and if students can use knowledge, skills, and competence from the simulation in practise.

Active learning approaches are recommended in higher education. The simulation of palliative care cases is one method to gain competence necessary for nursing, particularly when including the issues of knowledge, skills, and competence.

9. Conclusion

The findings of this study indicate that simulating palliative care cases, the practical performance and the reflection connected cases and performance, provide courage to seek palliative care situations in practise. Courage is used and received through active participation and debriefing. Realistic cases stimulate the participants' senses and feelings. Simulation is described as an out of the comfort zone experience and a safe environment for learning. The focus changes from action-oriented to being present. It is necessary to decrease evaluation and be aware of the learning environment to ensure positive outcomes. In this study, the participants reported that they used the simulated experience in practise to develop relationships with patients and relatives and for clinical judgements and decision-making. Continuity in learning through simulation combined with practise was emphasised.

Conflicts of interests

None declared.

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Approval

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