UNDERGRADUATE NURSING STUDENTS’ EXPERIENCES ENGAGING IN SERIOUS ILLNESS COMMUNICATION

UNDERGRADUATE NURSING STUDENTS' EXPERIENCES ENGAGING IN SERIOUS ILLNESS COMMUNICATION AND PERCEPTIONS OF SERIOUS ILLNESS CONVERSATION GUIDE TRAINING: A QUALITATIVE DESCRIPTIVE STUDY

By

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ABSTRACT

Background: While serious illness communication is an important aspect of nursing care, it is recognized as an area of practice for which nursing students are not adequately prepared. Communication tools such as the Serious Illness Conversation Guide (SICG) may help address these gaps in knowledge and skill.

Aim: The aim of this study is to explore undergraduate nursing students' experiences engaging in serious illness communication and their perceptions about participation in a SICG workshop that aimed to improve such communication.

Methods: A qualitative descriptive approach was used. One-on-one, semi-structured interviews were conducted with eight undergraduate nursing students at McMaster University who had attended SICG training. Critical incident technique was used to elicit participant accounts of engaging in serious illness communication at their professional practice placements. Data were analyzed using qualitative techniques. Participants were surveyed to assess perceptions of the SICG workshop.

Findings: Three themes related to undergraduate nursing students' experiences engaging in serious illness communication after receiving SICG training were: a) serious illness communication is challenging to enact, b) finding moral and ethical ground, and c) fitting into the culture of the professional practice setting. Three themes related to nursing students' perceptions of the SICG workshop were: a) applicability of SICG training to practice, b) strengths of SICG training, and c) limited opportunities to develop competence.

Conclusions: Nursing students are challenged by serious illness communication in their practice. Findings support the integration of educational resources aimed to better prepare them for critical communication knowledge and skills on entry-to-practice.

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CIT	Critical incident technique
RN	Registered Nurse
SICG	Serious Illness Conversation Guide

CHAPTER 1- INTRODUCTION

More than 270,000 Canadians die each year, and given the aging of the population, it is estimated that by the year 2026, there will be 40% more deaths annually than in 2010 (Government of Canada, 2018). Furthermore, approximately 90% of Canadians will eventually die due to a serious, prolonged illness (Government of Canada, 2018). The term “serious illness” refers to chronic, progressive diseases such as heart failure, chronic obstructive pulmonary disease, chronic kidney failure, dementia, and advanced cancer; they are controllable but not curable (Ferrell et al., 2018). When individuals and their families face serious, life-limiting illness, many difficult decisions need to be made (Bernacki & Block, 2014; Parry et al., 2014). Yet, less than one third of patients with end-stage medical conditions have serious illness conversations with their healthcare providers (Bernacki & Block, 2014). In patients with advanced cancer, the first conversations about end-of-life issues occurred only 33 days before death and 55% of those initial conversations occurred in a hospital setting (Mack et al., 2012). When discussions about goals and preferences do occur, they tend to take place late in the course of illness and focus on medical interventions and treatments rather than a patient’s values and priorities for care and end-of-life (Lakin et al., 2017).

Canadians experiencing serious illness need quality care and support, and families need effective and timely communication in coping with grief and bereavement (Government of Canada, 2018). However, effective communication supports more than end-of-life care. Rather, it is essential in improving quality of life throughout the serious illness trajectory, even if death is not an imminent outcome (Bernacki & Block, 2014; Geerse et al., 2019). Patients’ priorities may evolve over time, making conversations throughout the illness trajectory essential to the wellbeing of individuals and their families. Serious illness communication has been shown to be a key element in helping ensure that patients receive the care they want, in alleviating anxiety, and in supporting families (Bernacki & Block, 2014). The likelihood that patients make choices consistent with their stated goals, values, and preferences is also increased when these conversations occur (Lakin et al., 2017).

With support provided by the Government of Canada, the Canadian Hospice Palliative Care Association (CHPCA) released a document entitled “The Way Forward National Framework: A Roadmap for an Integrated Palliative Approach to Care” (2015). This document identified best practices that could help all care settings implement an integrated palliative approach to care and that highlighted the need for excellent and ongoing communication. The document provided a clear and concise definition of an integrated palliative approach to care:

> Care that focuses on meeting a person’s and family’s full range of needs – physical, psychosocial and spiritual – at all stages of a chronic progressive illness. It reinforces the person’s autonomy and right to be actively involved in his or her own care – and strives to give individuals and families a greater sense of control. It sees palliative care as less of a discrete service offered to dying persons when treatment is no longer effective and more of an approach to care that can enhance their quality of life throughout the course of their illness or the process of aging. It provides key aspects of palliative care at appropriate times during the person’s illness, focusing particularly on open and sensitive communication about the person’s prognosis and illness, advance care planning, psychosocial and spiritual support and pain/symptom management. As the person’s illness progresses, it includes regular opportunities to review the person’s goals and plan of care and referrals, if required, to expert palliative care services. (CHPCA, 2015)

This approach to care acknowledges that most people want to be truly informed about their illness and prognosis, and to have an opportunity to talk openly about their health, their hopes and fears, and about the possibility of dying. An integrated palliative approach to care ensures that people are asked about their care goals and preferences and that they are encouraged to revisit those goals and discuss how they may change over time (CHPCA, 2015). You et al. (2015) reported that 80% of older adult Canadian patients, preferred a patient-centered and palliative approach to end of life without life-prolonging measures.

Nurses make up the largest group of health care workers in Canada and have the most continuous contact with patients in various settings (Rietze et al., 2018). Although many healthcare professionals have the opportunity to engage in formal, planned conversations about serious illness prognosis and end-of-life planning, nurses are often thrown into situations where these conversations occur in an informal, unplanned manner (Lakin et al., 2017). Often, these conversations happen during moments of care at the bedside (Strachan et al., 2018). Unfortunately, many nurses are uncomfortable with conversations of this nature and these opportunities are missed, which can lead to reduced quality of life for the patient (Lakin et al., 2017). Furthermore, nurses may feel that engaging in these types of discussions can reduce hope or cause emotional harm to the patient and their families (Bernacki & Block, 2014). In response to this practice gap, an evidence-informed Serious Illness Care Program was created by a team of palliative care experts (Ariadne Labs, 2020; Bernacki & Block, 2014). The program is a system-level intervention that centers around the Serious Illness Conversation Guide (SICG). The SICG offers healthcare professionals the language they need to engage in serious illness communication (Geerse et al., 2019). Serious illness communication is a discussion or series of discussions between a clinician and patient that starts early in the course of serious illness and focuses on the patient's values, goals, and care preferences (Bernacki et al., 2015). The SICG is gaining particular momentum in Canada where it has been recently used to help nurses and other healthcare professionals engage in conversations with patients who are seriously ill and their families (BC Centre for Palliative Care, 2020). It has already been tested in a variety of settings with positive results, including in oncology, long-term care, and with end-stage renal patients (Bernacki et al., 2015; Lamas et al., 2017a; Lamas et al., 2017b; Mandel et al., 2017, Paladino et al., 2020).

Numerous studies indicate that although new graduate nurses are likely to encounter the need for including serious illness communication in their nursing practice, the vast majority of undergraduate nursing education curricula does not provide a consistent or strong foundation for the development of this skill (Croxon et al., 2018; Josephsen & Martz, 2014; Zheng et al., 2016). Furthermore, undergraduate nursing students and new graduate nurses themselves indicate that they lack the skills and feel inadequately prepared to engage in serious illness communication (Josephsen & Martz 2014; Sanford et al., 2011). Undergraduate nursing education should promote nurses' critical role in serious illness conversations (Strachan et al., 2018). This requires investments to be made in undergraduate nursing education to help graduating nurses attain essential communication abilities that are embedded in generalist palliative care knowledge and skills (Morrison, 2018). While communication that relates to end-of-life is viewed as an important aspect of undergraduate nursing education, communication with patients and families is reported as the most challenging aspect of caring for dying patients (Croxon et al., 2018; Ranse et al., 2018). Most new graduate nurses acknowledge the importance of serious illness conversations, although few are confident in their role or adequately prepared in this skill (Croxon et al., 2018). The Canadian Association of Schools of Nursing (CASN, 2011) has outlined competencies and indicators regarding end-of-life communication in nursing curricula. These competencies are guidelines for Canadian nursing schools designed to help maintain consistent standards and entry-to-practice competencies regarding end-of-life care education. Despite these guidelines, undergraduate nursing students have inconsistent preparation related to communication regarding the implications of serious illness on end-of-life issues (Croxon et al., 2018). Furthermore, little is known about the actual experience of nursing students engaging in serious illness communication and how these might impact the knowledge, skills, and attitudes that are carried into professional nursing practice.

Purpose Statement

The purpose of this study is to explore undergraduate nursing students' experiences of engaging in serious illness communication at their professional practice placements and to understand their use of and the perceived influence of the SICG training on such communication. Exploration of this phenomenon is needed to inform future integration of appropriate educational resources for undergraduate nursing students that supports their engagement in serious illness conversations with patients and families.

The better equipped nurses are to communicate with patients and their families experiencing serious illness, the better the care provision and care experiences will be for patients and their families (Bernacki & Block, 2014). The findings of this study could potentially impact decisions about the purposeful inclusion of serious illness communication skills training in undergraduate nursing curricula. The study findings will also be important in a research context. Although research involving the SICG has been underway with health professionals, there is no research to date that explores the use of this tool with undergraduate nursing students.

This study will provide a foundation for further studies to explore the use of SICG training in the context of undergraduate nursing education.

CHAPTER 2: SELF-REFLECTION

Reflexivity in qualitative research involves awareness of oneself in the research process (Berger, 2015). A value-free position of neutrality is impossible to maintain, and so this should never be the aim in qualitative research (Bradbury-Jones, 2007). Rather, Thorne (2016) describes "positioning the researcher within the ideas" (p. 75) and explains that this includes locating the specific kinds of concerns that contributed to the generation of the area of interest. These concerns reveal the motivation, biases, and consequent angle of the inquiry, and as a result it becomes possible to determine whether data collection and analysis are informed or skewed by these early conceptions (Thorne, 2016).

Readiness for Communicating about Death and Dying

My interest in serious illness communication was initially sparked as an undergraduate nursing student doing my consolidation placement on an acute medical floor in a community hospital. My first experience caring for a patient at the end-of-life occurred only a couple weeks into my placement. Midway through the day, one of our patients began to quickly decline. As I had been looking after this patient mostly independently throughout the day, his family called for me and had questions about what was happening. His wife was especially distressed and she asked me: "How much time does he have?" I felt completely overwhelmed and I did not feel confident explaining what was happening to the family and supporting them in this difficult time. Thankfully, I had a very experienced preceptor who patiently spoke to the family with me and supported me in the process of communicating with the patient and family. I became very emotional after this experience because I had felt helpless and unprepared to communicate and support the patient and family during this challenging transition.

Difficulty Finding the Right Words

Shortly after graduating as a Registered Nurse (RN), I accepted a part-time position on an acute medical floor at a small community hospital, where I continue to work. Several days into my new nursing career, I was confronted with the first of many challenging serious illness conversations with patients and their families. I was caring for a patient who had come to the hospital following a fall at home and after running several routine diagnostic tests, she was unexpectedly diagnosed with an end-stage terminal cancer. I was working the night shift and was about to enter the patient's room when the patient's daughter grabbed my arm and asked me "Is she dying?" I was stunned into silence and felt completely unprepared to answer her question. Many thoughts raced through my head, "How much does the family know?", "How much information should I tell them?", "Where do I begin?" I was not prepared to have this conversation and my first instinct was to run and hide, to let someone else broach the unfamiliar, scary topic. This conversation was the first of many serious illness conversations that I would have as a new graduate nurse.

Recognizing the Challenges of Serious Illness Communication

As a new graduate nurse, I am uniquely positioned in a situation where I have the opportunity to experience firsthand the challenges that many new graduate nurses face. As my unit regularly accommodates groups of undergraduate nursing students for their clinical placements, I am also able to closely observe the interactions that these students have with patients in the clinical setting. My initial lack of experience and skill engaging in serious illness communication made me aware of the need for increased undergraduate nursing education and continuing professional support in this area. Many experiences later, I feel more confident engaging in serious illness communication but I still have difficulty finding the right words at times.

I was surprised to find very little literature that explained the experiences of undergraduate nursing students and new graduate nurses engaging in serious illness communication, and few validated tools to specifically guide serious illness conversations in professional practice. With the perspective of having been an undergraduate nursing student recently and now understanding the realities of working as a new graduate nurse, I saw my graduate thesis work as an opportunity to both explore an area of interest from my practice and create knowledge that could support educators in better facilitating the learning needs of undergraduate nursing students.

CHAPTER 3: LITERATURE REVIEW

This literature review aimed to inform the study's purpose by answering the following questions:

1. How is serious illness communication described in the context of a palliative approach to care, advance care planning, and goals of care communication?
2. How do nursing students and new graduate nurses experience engaging in serious illness communication in the clinical setting?
3. What education initiatives related to serious illness communication have been implemented in nursing education and practice?

In addition to answering these questions, this literature review will describe the utilized search strategy, synthesize relevant findings, and identify gaps in current literature. In this review, the term *serious illness communication* is used to include discussions between health professionals and patients and/or their families about advance care planning, goals of care and end-of-life discussions for patients with serious illness (Bernacki & Block, 2014). It is also used to emphasize that the target population and impact of these discussions are not reserved solely for the end-of-life but rather for care throughout the entire serious illness trajectory. In this review of specific studies, the terms used by the authors will be maintained (e.g., *end-of-life care*). See Appendix A for a glossary of terms.

Search Strategy

Four database searches were conducted to find relevant literature. The databases used included AgeLine, CINAHL, PsycInfo, PubMed, and MEDLINE. In addition, the reference lists of key studies were hand searched and relevant citations were selected for review. This method uncovered grey literature relevant to the topic. Clinical commentaries, unpublished studies, dissertations, and editorials were excluded from the search. Only studies written in English were considered.

The first search was conducted to find relevant literature regarding serious illness communication within a palliative approach to care, advance care planning, and goals of care communication. The key search terms used consisted of: *serious illness communication*, *end-of-life communication, advance care planning,* and *goals of care communication*. A total of 725 articles were retrieved from all five databases. Once duplicated articles were removed, 614 papers remained. Of these, four systematic reviews were selected and reviewed on the topic of serious illness communication.

The second search focused on nursing students' experiences engaging in serious illness communication. Key search words included: *nursing students*, *undergraduate nursing students*, *serious illness communication*, *end-of-life communication*, *clinical*, *experiences*, *perceptions*, *attitudes*, *views*, and *feelings*. No literature was found to describe nursing students' experiences using the keyword *serious illness communication*, so the search was then adapted to include *end-of-life communication*. A total of 205 articles were retrieved from all five databases. Once duplicated articles were removed, 160 articles remained. No relevant systematic reviews or meta-analyses were found on this topic. Five single studies were selected that explored the experiences of nursing students engaging in serious illness communication.

A third search was conducted for studies related to new graduate nurses' experiences engaging in serious illness communication. Key words included *graduate nurses*, *new graduate nurses*, *serious illness communication*, *end-of-life communication*, *clinical*, *experiences, coping, perceptions*, *attitudes*, *views*, and *feelings*. Again, no literature was found to describe new graduate nurses' experiences using the keyword *serious illness communication*, so the search was then adapted to include *end-of-life communication.* A total of 75 articles were retrieved from all five databases. Once duplicated articles were removed, 62 articles remained. Two systematic reviews were selected related to new graduate nurses' experiences engaging in communication with seriously ill patients and two relevant single studies were selected.

The final search was focused on education initiatives related to serious illness communication. Key words included *serious illness communication*, *end-of-life communication*, *education, training, intervention, nurs*, profession*.* All literature related to the SICG was accessed through the research section of Ariadne Labs Serious Illness Care Program (2020). A total of 380 articles were retrieved from all five databases and the research section of Ariadne Labs Serious Illness Care Program. Once duplicated articles were removed, 324 articles remained. Two systematic reviews were selected that evaluated the effectiveness of communication interventions in training healthcare professionals and four education initiatives were chosen and further summarized.

The eight systematic reviews and six single studies that provided the foundation for this literature review were summarized and critically appraised using the Critical Appraisal Skills Programme (CASP) (2014) checklists for qualitative studies, trials, and systematic reviews (Appendix B). These checklists provide specific questions to help address the issues of validity of findings, the study's results, and the extent to which the results can be applied locally (CASP, 2014).

Serious Illness Communication

Serious illness communication in the context of a palliative approach to care.

The quality of serious illness communication directly determines patient and family outcomes (Fawole et al., 2013). When clinicians engage in discussions about a patient's goals of care early in the course of serious illness, there are beneficial outcomes for patients such as better quality of life, less aggressive treatments near death, and earlier referrals to hospice (Bernacki & Block, 2014). Sawatzky et al., (2016) found that there is misalignment between the concept of palliative care and how it is currently offered in the healthcare system. They found clear communication throughout the illness trajectory to be essential, particularly in relation to conversations about advance care plans, goals of care, and "breaking bad news". Although serious illness conversations are typically associated with specialized palliative care, they need to be adapted beyond that to facilitate sensitive communication with individuals who have not yet identified themselves as being someone with a serious illness that will eventually lead to death (Sawatzky et al., 2016).

One of the reasons physicians reported not engaging in serious illness conversations was due to their lack of comfort and feelings of inadequacy related to managing the emotional and behavioural responses of their patients (Bernacki & Block, 2014; Geerse et al., 2019). Parry et al. (2014) found that conversations about illness progression and end-of-life can be initiated and pursued in a variety of ways and result in different consequences. For example, "fishing questions" and "indirect talk" were found to be sensitive communication practices but can also make it easy for patients to avoid engaging in important topics. Hypothetical questions were found to encourage conversation about specific topics (Parry et al., 2014).

Serious illness communication in the context of advance care planning. Effective communication at the appropriate time during the serious illness trajectory improves individuals' quality of life (Mack et al., 2012; Wright et al., 2008). Although patients expect their health care providers to initiate advance care planning discussions, only 8% of Canadian older adults reported having had an advance care planning discussion with a nurse during their hospital admission (Rietze et al., 2018). Factors identified as contributing to a general lack of advance care planning include: lack of public awareness of advance care planning, negative attitudes of health care providers, limited capacity of primary care providers due to lack of training in advance care planning, poor integration of advance care planning into workflow, and lack of system and policy supports (Howard et al., 2018). Mack et al. (2012) found that when patients engaged in advance care planning, they were more likely to choose palliative versus aggressive interventional therapies. Choosing less aggressive therapies led to improvements in quality of life for those patients (Mack et al., 2012). Additionally, families of patients with serious illness who had advance care planning reported decreased levels of anxiety and depression after the patient's death (Detering et al., 2010). When advance care planning is not initiated at the appropriate time, the care provided at end-of-life may not necessarily align with an individual's preferences (MacKenzie et al., 2018).

Serious illness communication refers to discussions between health care providers and patients about their values, goals, and care preferences within the context of a serious illness. These discussions are revisited throughout the course of the serious illness and may include advance care planning, goals of care discussions and shared decision-making about end-of-life care options (Bernacki & Block, 2014). Hospice Palliative Care Ontario (HPCO) describes and differentiates between advance care planning, goals of care and decision-making discussions (HPCO, 2016). The aim of advance care planning is to give individuals the opportunity to discuss their values and wishes so that these may be known for future healthcare decision making, particularly if a person could not speak for themselves. It should be considered an iterative conversation that recurs over the course of a serious illness. Ultimately, goals of care discussions should be based on both the patient and the healthcare provider understanding the patient's values and goals (HPCO, 2016).

While advance care planning informs goals of care conversations, there are important differences. Latimer (1998) suggests that goals of care should consider the patient's experience of the illness, the patient as a person, the illness, and the possible treatments. They should be established based on the perspectives and input of the patient, family and health care team (Latimer, 1998). However, there is often a reluctance to engage patients and families in goals of care conversations until a patient is in the end stage of a serious illness (Mack et al., 2012). Furthermore, these conversations are often framed around medical interventions when the focus should be understanding the patient's values, beliefs and concerns in relation to possible future care (Howard et al., 2018). Goals of care conversations are an essential component of providing patients and their families with quality care that aligns with what is most important to them (Bernacki & Block, 2014).

Nursing Students' Experiences Engaging in Serious Illness Communication

Gaps in education. Undergraduate nursing curricula currently place a large focus on students' learning about acute care interventions in the context of medical and surgical nursing (Gillan et al., 2014; Rietze et al., 2018). As a result, there continues to be large variation in the end-of-life content included in undergraduate nursing curricula (Brajtman et al., 2007; Sanford et al., 2011). Brajtman et al. (2007) found that although end-of-life care content was integrated throughout the four years of an undergraduate nursing program, the education was not reflected in the course descriptions which informed the learning objectives for students. Thus, depending on the individual faculty member's knowledge and experience in the topic area, there may be more or less end-of-life care content included in courses (Brajtman et al.,2007). Henoch et al.,

(2017) followed the development in nursing students' attitudes towards caring for dying individuals throughout their undergraduate degree and found that although communication was viewed as an important issue in palliative care education, students' attitudes related to the specific items about communication did not change significantly in the study. These findings could indicate that training related to communication with patients at the end-of-life is insufficient (Henoch et al., 2017).

Perceived knowledge, confidence and skill. Nursing students perceive that they have an inadequate level of knowledge and skill in communicating with dying patients and their families (Josephsen & Martz, 2014; Sanford et al., 2011). In a study conducted by Josephsen and Martz (2014), nursing students indicated that they were ''less adequately'' or ''not adequately'' prepared to address communication with patients and families about end-of-life issues. The study identified that a lack of faculty preparedness and knowledge of how to teach end-of-life care content was a barrier in strengthening students' knowledge in this area (Josephsen &Martz, 2014).

Brajtman et al. (2007) evaluated fourth year nursing students' attitudes, knowledge and skills and found that although palliative and end-of-life care knowledge improved between first and final year, clinical educators did not observe the effects of this knowledge on communication in end-of-life care. Clinical educators expressed concerns regarding students' knowledge of what to do and how to communicate in actual clinical settings around seriously ill and dying patients. Furthermore, 30% of graduating students said that they felt unprepared to care for dying patients, particularly in the context of communicating with patients and their families at the end-of-life. This is reflected in the student responses to the Frommelt questionnaire and the low scores received for the statement. One of the statements was "I would be uncomfortable talking about death with the dying person", and students were asked to identify their position by indicating a response from strongly agree to strongly disagree. Of the 58 students, 13 stated that they agreed with the statement and two indicated that they strongly agreed (Brajtman et al., 2007).

Although serious illness communication is a challenging and complex skill, graduating nurses will be faced with situations that require this knowledge upon graduation and as they move into various workplaces (Calvin et al., 2009). Adequate education, clinical experience and support during end-of-life care experiences can assist nursing students to develop the knowledge, skill and confidence they require to engage in appropriate serious illness communication with patients and their families (Ranse et al., 2018).

Emotional response. Although many students have previously experienced death, caring for dying patients may provoke feelings of sadness, anxiety and powerlessness (Gallagher et al., 2014, Parry, 2011). These feelings are often related to not knowing what to do or say in situations at the end-of-life (Parry, 2011; Ranse et al., 2018). Parry (2011) found that while students were able to acknowledge their feelings of anxiety in these situations, they lacked the necessary skills to cope with these feelings. Ranse et al. (2018) found that students attempted to suppress their negative emotions, even though they knew this strategy was not effective long-term. Debriefing with a clinical instructor and peers can be a helpful strategy for students after experiences related to end-of-life care, particularly in the context of communication (Gallagher et al., 2014; Sanford et al., 2011). Yet, in a study conducted by Gallagher et al. (2014), only 38.5% of students were offered the opportunity to debrief following a patient death.

Nursing students' first experience with death can influence their future reactions to end-of-life care (Ranse et al., 2018). If students have a negative first experience they may attempt to actively avoid these situations and feel that they do not have the skills to be helpful. If their first experience was positive, it usually contributes to nursing students' positive engagement with end-of-life care in the future (Ranse et al., 2018). The way that students see other nurses providing care to seriously ill patients can also have an emotional influence on students (Sanford et al., 2011; Wallace et al., 2009). Sanford et al. (2011) studied nursing students' experiences of caring for patients with cancer and found that students described situations where little to no advance care planning and goals of care communication had been provided for cancer patients. These situations were found to be distressing to students, as they perceived these to be a lack of caring by nurses (Sanford et al., 2011). These findings highlight a need for training in communication skills for end-of- life care to meet both the information and emotional needs of caring for dying patients and their families (Ranse et al., 2018).

Recommendations for nursing education. Palliative care education, including the knowledge and skills related to serious illness communication, is an important factor in preparing nursing students to provide patients and their families with appropriate end-of life-care. It is also the most significant factor shaping nursing students' attitudes toward caring for dying patients (Croxon et al., 2018; Gillan et al., 2014). Nursing students learn about serious illness communication in the context of end-of-life care through a variety of approaches (Brajtman et al., 2007; Sanford et al., 2011). Students identified potentially useful education interventions such as role play, case scenarios and exposure to seriously ill patients in a less acute environment (Sanford et al., 2011). They emphasized that clinical exposure to serious ill patients and their families was the best preparation for improving their skills (Sanford et al., 2011). Wallace et al. (2009) found that students in different levels of their undergraduate education needed different levels of knowledge and support in relation to end-of-life care. The students just starting in the program needed more basic knowledge related to end-of-life care while the senior students wanted more specific knowledge and skills such as providing care to patients who are imminently dying and communicating with their families appropriately (Wallace et al., 2009).

Henoch et al. (2017) found that nursing students' perceived confidence and knowledge related to communication with seriously ill patients did not improve throughout the course of their undergraduate program. This indicated that the training related to communication with seriously ill patients was likely insufficient. The study concluded that to help students feel more prepared to care for dying patients and their families, undergraduate nursing education needs to emphasize a focus on communication and reflection (Henoch et al., 2017).

The Canadian Association of Schools of Nursing (CASN) created an advisory group which provided a document outlining the palliative and end-of-life care knowledge and skills that are required for the entry-to-practice of new graduate nurses. The document outlined national, consensus based competencies and indicators to facilitate greater integration of this area of nursing in undergraduate curricula in Canada. Competencies related to serious illness communication included communicating respectfully and compassionately with patients and their families, facilitating conversations related to end-of-life care options, and documenting communication about patients' choices regarding their end-of-life care options (CASN, 2011). While CASN's competencies and indicators for palliative and end-of-life care offer some guidance to nurse educators for curricular design for serious illness communication, they are now nine years old and should be reviewed and updated for continued relevance.

New Graduate Nurses' Experiences Engaging in Serious Illness Communication

Role of the new graduate nurse. New graduate nurses feel that palliative care is an important part of their work and that the skills used in that area of practice are relevant in a variety of nursing settings (Croxon et al., 2018). Yet new graduate nurses often report entering the workforce with no prior experience of caring for patients at the end-of-life (Ranse et al., 2018). They are challenged to balance this gap in knowledge and experience while also attempting to master basic nursing skills (Barrere & Durkin, 2014).

In a study conducted by Barrere and Durkin (2014), new graduate nurses indicated that it was important to find balance in the role of being a nurse while maintaining compassion and without becoming too emotionally involved. The study found that a common theme amongst new graduate nurses was difficulty finding the right words to comfort patients and families during the dying process, despite recognizing that this was an important role of the nurse (Barrere & Durkin, 2014).

A best practice guideline was released from the Registered Nurses' Association of Ontario (RNAO) regarding implementation of a palliative approach to care in the last year of life (2020). It emphasized the importance of effective and therapeutic communication in understanding the needs of individuals and their families at the end-of-life. An interprofessional approach to palliative care was identified as a facilitator in effective communication. It was acknowledged that this sort of communication was difficult for nurses and that further communication training was needed. The document identified gaps in the literature including the impact of nurse's communication at the end-of-life on family experience and emotional coping, and the development of approaches for integrating formal evaluation into the development and implementation of end-of-life educational programs. It also made recommendations to improve communication education for undergraduate nursing students and new graduate nurses. Suggested learning strategies to incorporate into nursing curricula included pre- and post-clinical conference discussions, simulation, and interactive classroom activities (RNAO, 2020).

A joint position statement was released by the Canadian Nurses Association (CNA), the CHPCA and the Canadian Hospice Palliative Care Nurses Group (CHPC-NG) regarding the palliative approach to care and the role of the nurse (2015). The role of the nurse was explained as including the initiation of communication that respects people's values and healthcare wishes. Furthermore, the conversation about end-of-life care should be started early and periodically revisited throughout a person's life (CNA, CHPCA & CHPC-NG, 2015).

Perceived readiness. Communicating with patients and their families regarding the end-of-life and its issues is ranked as a highly stressful experience for nurses (Calvin et al., 2009; Gillan et al., 2013). New graduate nurses identify this as a challenging area of practice for which they do not feel adequately prepared (Croxon et al., 2018; White & Coyne, 2011; Zheng et al., 2016). They report relying on cumulative job experience to fill their gaps in knowledge (Croxon et al., 2018; Dame & Hoebeke, 2016; Erickson et al., 2015). Barrere and Durkin (2014) interviewed twelve new graduate nurses who had been in practice for approximately one year. End-of-life communication was found to be particularly challenging because they were still in the process of mastering basic nursing care while also needing to provide complex end-of-life care to their patients; care provision was distinguished from and prioritized over communication skills (Barrere & Durkin, 2014).

Croxon et al. (2018) found that although new graduate nurses acknowledged the importance of end-of-life conversations, few felt confident in their role or adequately prepared in this skill. Particularly, communicating with families was viewed as the most challenging aspect of end-of-life care (Croxon et al., 2018; Zheng et al., 2016). Yet new graduate nurses reported that they had not realized they were unprepared to address this area of nursing until they were in practice (Malone et al., 2016). In their systematic review, Zheng et al. (2016) found that there were a variety of feelings and challenges experienced by new graduate nurses when faced with patient death, including feeling inadequate in communication when providing end-of-life care. Despite these perceived inadequacies, new graduate nurses reported feeling left alone to provide care for dying patients, which escalated their negative feelings (Zheng et al., 2016).

Preparation during undergraduate nursing education. New graduate nurses perceive that their undergraduate nursing education had not adequately prepared them to care for patients at the end-of-life, including communicating with patients and families in this context (Croxon et al., 2018; Zheng et al., 2016). Although skills in having "difficult" conversations was something that new graduate nurses perceived they lacked preparation for, they also admitted to often having avoided engaging with end-of-life care and communication when the opportunity was available to them during their studies (Croxon et al., 2018). Malone et al. (2016) suggested a need for inclusion of high quality palliative care education in nursing curricula and for postgraduate training to continue in order to address the gap in knowledge experienced by new graduate nurses. Education interventions may help new graduate nurses feel more confident in the essential skills of having "difficult" conversations and communicating effectively with patients and their families regarding end-of-life issues (Malone et al., 2016).

Education Initiatives for Healthcare Professionals Related to Serious Illness Communication

Two systematic reviews were selected that evaluated the effectiveness of communication interventions in training healthcare professionals who had graduated from various professional programs (Chung et al., 2016; Lord et al., 2015). Lord et al. (2016) explored the effectiveness of end-of-life communication-skills training interventions for those who cared for non-cancer patients in an acute care setting. Ten articles were selected for review, mostly quantitative studies and some mixed-methods studies. Participants included registered nurses, healthcare assistants, consultants, and medical trainees. The review found that few studies have focused on end-of-life communication-skills training when providing care to patients who did not have cancer and in acute care settings. Based on the published studies, communication-skills training interventions were found to have positive effects on staff behavior with regard to communication about the end-of-life with patients and families. Furthermore, all of the studies reported that outcome measure scores had improved post-intervention, which suggested that the training positively changed staff communication. A need for further research with control groups and longer follow-ups to test the effectiveness of interventions was identified (Lord et al., 2016). Chung et al. (2016) conducted a systematic review to evaluate the effectiveness of end-of-life communication skills educational interventions for healthcare professionals, compared to usual curriculum. Twenty articles that were either randomized controlled trials or prospective observational studies with a control group were selected for review. Overall, the review suggested that end-of-life communication training may improve healthcare professionals' self-efficacy and knowledge compared to usual teaching. Importantly, the effect of communication training on the experiences of patients and their families was not evaluated (Chung et al., 2016).

While training of nurses in both pre- and post-licensure contexts has been reported, four specific communication training initiatives were identified in the literature as facilitating the delivery of appropriate serious illness communication. These include Australia's Palliative Care Curriculum for Undergraduates Project (PC4U) (PC4U, 2020), Sage & Thyme (Connolly et al., 2010), SPIKES (Baile et al., 2000), and the SICG (Ariadne Labs, 2020).

Australia's PC4U. The Australian Government addressed the need for palliative care education for all medical, nursing, and allied health with the PC4U Project. The project offers evidence-based learning resources for students and facilitators, as well as professional development activities. Several studies have demonstrated the value of dedicated PC4U palliative care education as part of student preparation prior to clinical placements. Nursing students reported palliative care education in the form of PC4U prior to their placement on a palliative care unit contributed not only to their knowledge of palliative care but also increased their understanding of the environment and related expectations (Gallagher et al., 2014). Students also felt that the majority of the skills, knowledge and experiences gained during their clinical placement were transferrable to other clinical practice settings, particularly communication with patients and families (Gallagher et al., 2014). Several studies evaluating the PC4U program in the context of undergraduate nursing education have found that nursing students believe that a course in palliative care that is inclusive of communication skills training should be a core component of an undergraduate nursing program (Bush & Shahwan-Akl, 2013; Gallagher et al., 2014).

Sage & Thyme. Sage & Thyme is a framework that guides learners to apply patient-centered care for listening and responding to concerns by listening fully, holding back with advice, and inquiring about the patient's own support and solutions before offering any advice or information (Connolly et al., 2010). The model is based upon the idea that individuals experiencing serious illness can understand and take some responsibility for their own health and wellbeing and that a helpful relationship can be built if the healthcare provider listens carefully and responds appropriately. The Sage & Thyme Foundation Level Workshop is a three-hour training workshop that has been implemented in the training programs of many hospitals, universities and hospices in the UK (Connolly et al., 2010).

The Sage & Thyme Foundation Level Workshop was found to significantly increase communication skills knowledge, self-efficacy, and outcome expectancy of hospital health care workers (Connolly et al., 2014). Furthermore, the workshops have been successful in increasing the self-perceptions of confidence, competence and willingness to explore the emotional concerns of patients (Connolly et al., 2010). In the palliative care context, the Sage & Thyme model was found to be a useful way of enabling nurses to improve and maintain effective communication. The model helped to provide a structure for conversations and facilitated opening and closing of interactions which participants found useful (Griffiths et al., 2015; Martin et al., 2017).

SPIKES. SPIKES is a six-step protocol that was developed to help clinicians deliver "bad news" (Baile et al., 2000). S (Setting up), involves reviewing and preparing the plan for the talk by assessing the patient's P (Perception) to have the conversation. I (Invitation), involves inviting the patient to take part in the talk. Once the patient is open to talk, the patient is offered K (Knowledge) and information regarding the situation. Then the clinician must address the patient's E (Emotions) that follow, and respond in an empathetic way, Lastly, S (Strategy & Summary), is a summary of the information provided to ensure that the patient correctly understands the situation and further treatment (Baile et al., 2000; Marschollek et al., 2019). Marschollek et al. (2019) evaluated how effectively the SPIKES protocol was implemented by physicians in an oncology setting and found that improvements were needed the areas of "Perception", "Invitation", and "Summary". Little and Bolick (2014) found that the systematic approach of the SPIKES protocol helped prepare nursing students and new graduate nurses to have difficult conversations with patients and their families.

Serious Illness Conversation Guide

In 2011, the Serious Illness Care team at Ariadne Labs began to develop a program to help seriously ill patients better meet their goals of care (Ariadne Labs, 2020). A literature review was conducted by the team to identify gaps and barriers to the provision of high quality serious illness conversations. Based on the information obtained from the literature review, the Serious Illness Care Program was generated with the aim of facilitating the process of better and earlier serious illness conversations (Bernacki & Block, 2014). The Serious Illness Care Program is a six-part system-level intervention centered around the SICG (Appendix C). The SICG provides health care professionals with a systematic, patient-directed framework for conducting serious illness conversations that is crucial to gaining a full understanding about what is most important to patients. The guide addresses a patient's understanding of their illness, their preferences for information, their personal goals, their fears and worries, as well as their sources of strength, the abilities they find most important to their daily life, and how much their loved ones know about their wishes (Ariadne Labs, 2020). An interprofessional guide to using the SICG has been recently adapted by the Serious Illness Conversation Nurse Working Group to address the specific needs of nurses and allied health professionals. The adapted guide includes specific strategies to having serious illness conversations during care moments, which is common for nurses (Strachan et al., 2018).

The SICG builds on the foundational communication skills that are expected knowledge for Canadian undergraduate nursing students. The guide offers some words and phrases that can be helpful when engaging in serious illness conversations, but it is not scripted. Rather, the intention is to encourage all clinicians to have earlier serious illness conversations and to be truly engaged in these conversations. It consists of steps to help patients talk about their goals and values: setting up the conversation, assessing the patient's illness understanding and information preferences, sharing prognosis*,* exploring key topics, and closing and documenting the conversation (Ariadne Labs, 2020).

The SICG has already been tested in a variety of settings with positive results (Bernacki et al., 2015; Lamas et al., 2017a; Lamas et al., 2017b; Mandel et al., 2017, Paladino et al., 2020). Research continues to be undertaken to determine the usefulness of the SICG as well as the barriers that healthcare providers face when implementing it in the clinical setting (Ariadne Labs, 2020). However, the SICG has never been tested in the context of undergraduate nursing education. Research with this population could be valuable in providing undergraduate nursing students and educators with a tool to facilitate education in serious illness communication during their undergraduate and post-licensure professional practice.

Serious illness conversations in clinical practice. In individuals over the age of 80 with renal failure, dialysis may offer little to no benefit, yet aggressive treatments continue to be selected in end-stage renal disease. Furthermore, 90% of patients with chronic kidney disease indicate that they wish to have serious illness conversations, yet only 10% of these patients report having these conversations with their health care provider. For this reason, conversations about goals of care are particularly important in this setting (Mandel et al., 2017). Mandel et al. (2017) identified the barriers to serious illness conversations in the dialysis population and reviewed best practices in conducting serious illness conversations. The barriers that they identified include inadequate healthcare provider training, a lack of time, and a focus on interventions and procedures. They found that serious illness conversations can help patients identify and share their goals, values, and preferences which ultimately facilitates the provision of goal-consistent care. They also suggested that serious illness conversations could be undertaken by any member of the interdisciplinary team including, nephrologists, nurses and social workers (Mandel et al., 2017).

A randomized controlled trial was conducted at the Dana-Farber Cancer Institute Preliminary to test the Serious Illness Care Program in an adult oncology setting (Bernacki et al., 2019; Paladino et al., 2019). The study's results were published in two articles and found that implementation of the Serious Illness Care Program resulted in earlier, more frequent, and more effective conversations between oncology healthcare professionals and their patients. The conversations were found to be very patient-centered and focused on the patient's goals and values (Bernacki et al., 2019; Paladino et al., 2019).

Lakin et al., (2017) conducted a study evaluating the implementation of the Serious Illness Care Program in fourteen primary care clinics, focusing on patients enrolled in the Integrated Care Management Program. This program matches patients with complex serious illness with a nurse care coordinator who works with the patients and their primary care physicians and social workers to develop a health care plan customized to them. They found that SICG training was well received by healthcare providers and increased the frequency of serious illness conversations. The majority of conversations that occurred involved more than one healthcare provider, which suggests that a team approach is an effective way for patients to engage in serious illness conversations. The study also found that medical records that described the occurrence of serious illness conversations were more comprehensive and accessible (Lakin et al., 2017).

Patients with chronic critical illness who survive an acute critical illness are often transferred to long-term care units in acute care hospitals where they may require prolonged mechanical ventilation, suffer recurrent infections, and experience delirium (Lamas et al, 2017a).

Approximately 50% of this population dies within one year. Unfortunately, the use of serious illness conversations in long-term care units in hospitals is limited and is associated with unmet palliative care needs (Lamas et al, 2017a; Lamas et al., 2017b). Lamas et al., (2017a) conducted a mixed methods study with patients at long-term acute care hospital and their surrogate decision makers. An interview guide was developed with open-ended questions derived from the SICG. Patients reported overly optimistic expectations for returning home and unmet palliative care needs. Both patients and their surrogates reported that the concept of serious illness care conversations were acceptable to them (Lamas et al., 2017a). Lamas et al., (2017b) conducted an exploratory study with patients at long-term acute care hospital and their surrogate decision makers. They found that serious illness conversations could be achieved within a relatively short timeframe and should be possible to integrate into clinical workflow. Furthermore, serious illness conversations were found to be acceptable to patients and their surrogate decision makers (Lamas et al., 2017b).

Literature Review Summary

In summary, there is a gap in knowledge about the unique experience of undergraduate nursing students engaging in serious illness communication and related education interventions. Current literature is based largely on observational studies and the outcomes of communication training based on nurse and healthcare provider perceptions of their self-efficacy for serious illness communication. Serious illness communication is a skill for which both undergraduate nursing students and new graduate nurses, feel they lack educational preparation (Barrere & Durkin, 2014; Bratjman et al., 2007; Croxon et al., 2018;). Despite consensus that nursing students need serious illness communication skills, the effectiveness of such skills in nursing students has not been rigorously assessed outside of laboratory or classroom settings. Their dependence on learning serious illness communication skills on the job in a happenstance way and after graduation, is concerning. Undergraduate nursing curricula should place particular emphasis on incorporating skills such as having conversations and communicating effectively with patients and families experiencing serious illness (Croxon et al., 2018). Students acknowledged that the majority of the skills, knowledge and experiences related to palliative care were transferrable to other clinical setting areas, particularly the skills of communicating with patients and families (Gallagher et al., 2014). However, new graduate nurses also admitted to often having avoided engaging in serious illness communication when the opportunity was available to them during their studies (Croxon et al., 2018). Thus, progress in educating undergraduate students for serious illness communication competence must be an intentional process of exposure, rehearsal and mentoring that is core to nursing curricula.

Although a variety of education initiatives for serious illness communication training exist, no tools have strong evidence to support their use in undergraduate nursing. Further research is needed on the effectiveness of these education initiatives in order to help prepare undergraduate nursing students for the inevitable practice experience of engaging in serious illness conversations with patients and families. The SICG is a tool that has been implemented in a variety of clinical settings for healthcare professionals with promising results. However, the tool's implementation and usefulness have never been evaluated in the context of undergraduate nursing education. The SICG may be helpful to undergraduate nursing students before and after their graduation.

It is evident from this review that further high-quality studies are needed with regard to undergraduate nursing students and new graduate nurses engaging in serious illness communication, and to evaluate serious illness communication education initiatives. These studies need to include reliable and valid measures and employ more robust methods, such as randomized controlled studies- a challenge in actual professional practice settings. There is also a need for qualitative research to further understand the experiences and preferences of undergraduate nursing students that could inform specific communication training initiatives within the Canadian context.

Research Questions

Based on this review of the literature, research questions were developed to explore the perceptions and experiences of fourth year undergraduate nursing students engaging in serious illness communication in professional practice placements after receiving educational training sessions on the SICG. The overarching research question is “In what ways do fourth year undergraduate nursing students who have participated in SICG training experience engagement in serious illness communication in professional practice placements?”

Sub-questions:

1. What are the perceptions of fourth year undergraduate nursing students about the ways in which the SICG training has influenced their professional practice?
2. What recommendations do fourth year undergraduate nursing students who have participated in SICG training have with regards to the SICG training in the undergraduate nursing curriculum at McMaster University?

CHAPTER 4: METHODS

This chapter will describe the research methods that were used in this study. The chapter begins with a discussion of the rationale for selecting a qualitative research design. Then the study design selected, qualitative description, will be summarized and strategies to promote rigor and trustworthiness will be discussed. Lastly, important ethical considerations for this study will be outlined.

Rationale for Selecting a Qualitative Research Design

Neergaard et al. (2009) defines qualitative research as “well suited for *"why"*, "*how"* and "*what"* questions about human behaviour, motives, views and barriers” (p.2). This study aimed to describe how undergraduate nursing students experienced engaging in serious illness communication with patients and their families in professional practice placements and their perspectives about the SICG workshop. In this study, the experiences and recommendations of undergraduate nursing students are acknowledged and recognized as important in shaping future education decisions regarding serious illness communication.

Study Design

The experience of undergraduate nursing students’ engaging in serious illness communication in their professional practice placements was explored using qualitative descriptive methodology. Qualitative description draws from a naturalistic perspective and examines a phenomenon in its natural state but is not limited to or aligned with a specific theoretical orientation (Sandelowski, 2000). As a result, it can provide a methodology and structure for studies while remaining flexible in the design (Kim et al., 2017). Sandelowski (2000) used the term qualitative description to acknowledge the wide-ranging approach to naturalistic inquiry as a legitimate and distinguishable method of qualitative research. This qualitative methodology requires using an inductive strategy and the researcher as the primary instrument to provide a rich description of a phenomenon from the perspective of the participant (Merriam & Tisdell, 2016). Qualitative description is useful for examining healthcare and nursing-related phenomena as it seeks to understand multifaceted and complex human experiences (Loiselle, 2011). In particular, it is helpful when focusing on the experiences of the health care team and their views on the patient interactions and the organization of the health care system (Neergaard et al., 2009).

Qualitative descriptive studies are based on the principles of constructivism which dictate that individuals construct reality or meaning while in interaction with their social worlds. Thus, using a qualitative descriptive methodology allows the researcher to discover how meaning is interpreted by individuals, how individuals construct their worlds, and what meaning they attribute to their experiences (Merriam & Tisdell, 2016). Qualitative description is also the methodology of choice when the goal is to refine an intervention or gain insights regarding a poorly understood phenomenon (Kim et al., 2017). Since the phenomenon of this inquiry is relatively new, approaching the study with a qualitative descriptive methodology allowed for the exploration of undergraduate nursing students' experiences in order to begin to understand teaching and learning about serious illness communication in the context of undergraduate nursing education.

Setting and Context

Data was collected from fourth year undergraduate nursing students at McMaster University who had participated in a SICG workshop during their final term in the BScN program. The SICG was introduced by nursing faculty at McMaster University; the university offers a well-established and world-renowned undergraduate nursing program. The program incorporates simulation-based learning and tutorial classes to promote the development of critical thinking and self-evaluation skills. A unique aspect of the program is problem-based learning (PBL) which emphasizes interpersonal skills, promotes self-directed learning and helps students develop leadership qualities. The program also places a strong emphasis on clinical practice throughout all four years of the program by providing students with a variety of professional practice placements including hospitals, agencies and community-based organizations. This allows students to gain experiences and skills in multiple environments and disciplines. McMaster University was also chosen for logistical reasons, as the sample is easily accessible to the researcher. Creswell (2013) states that in many cases it is appropriate to select a group of people who are closest to the researchers, particularly in the earliest stages of describing aspects of a shared experience.

The decision to recruit undergraduate nursing students in their fourth year was because the SICG training workshop was delivered to volunteers from this cohort. It was hypothesized that by their fourth year, more students will have had a variety of placements in which they may have been exposed to, engaged in, or recognized the need for serious illness communication. Developing knowledge and understanding of shared subjective experiences was facilitated by studying experiences of people with similar educational and clinical practice experiences (Patton, 2015).

Sampling

Purposive sampling is considered the gold standard of qualitative inquiry. This approach relies on a relatively small number of information-rich participants who are specifically chosen to explore the central phenomenon (Patton, 2015). Thorne (2016) states that this approach involves identifying in advance the "main groupings or conditions that you will want to have ensured you include in your study so the eventual findings you produce have the potential of ringing true or seeming reasonable to your intended audience" (p.99). Thus, purposive sampling was critical to ensuring that participants' individual experiences could contribute to a shared understanding of undergraduate nursing students' experience of communicating with patients with serious illness and their families.

Criterion purposive sampling was used to identify participants who were fourth year undergraduate nursing students and had completed SICG training. Criterion purposive sampling involves reviewing and studying all cases that meet some predetermined criterion of importance, which results in a comparison between the criterion cases and those cases without the criterion (Patton, 2015). This method of sampling is achieved by identifying in advance of the study the main groupings and conditions that will result in findings that have the potential of being relevant to the intended audience. Reviewing existing literature on the phenomenon being studied can be a useful source of guidance in identifying these groupings and conditions (Creswell, 2013). In this study, participants were eligible for inclusion in the study if they were: (a) a full-time fourth year undergraduate nursing student who has attended the SICG training; and (b) willing to participate in a one-on-one interview about engaging in serious illness communication regarding their professional practice. These criteria ensured that experiences engaging in serious illness communication relevant to the study setting and purpose were captured.

Multiple considerations were made regarding sample size which was restricted by the number of students in the SICG training. Flanagan's Critical Incident Technique (CIT) was used in the data collection process: it specifies critical incidents as the unit of analysis rather than individual participants (Flanagan, 1954). Using CIT, data saturation is typically reached when redundancy in the incidents appears (Flanagan, 1954; Woolsey, 1986). Given that CIT is largely determined by the number of incidents rather than participants, it was anticipated that a smaller number of participants would be needed. Similarly, in qualitative research studies, sample size is determined by what is needed to address the research questions and to satisfy the purpose of the study; more participants would not necessarily add more depth to the data collected (Creswell, 2013). Furthermore, as both SICG workshops only facilitated training for approximately 25 fourth year undergraduate nursing students, the pool of eligible participants was small. Based on these considerations, it was estimated that a purposive sample of 8 to 15 participants would be needed to reach data saturation and a new understanding of the phenomenon.

Recruitment

In January 2019, a 3.5 hour SICG workshop was conducted with 17 fourth year undergraduate nursing students who were enrolled in *N4K10: Professional Practice and the New Graduate* at McMaster University. In April 2019, another SICG workshop was conducted with students from various programs (including Nursing) from the Faculty of Health Sciences. This was a student initiated event through the Program for Interprofessional Education and Research (PIPER). The workshops included preparatory readings and viewing of selected audio-visual materials from Ariadne Labs (Appendix D). This material was meant to provide students with contextual information and engage them in thinking about serious illness communication. As per the School of Nursing policy, permission was sought from the Undergraduate Nursing Education Committee (UNEC) at McMaster University to approach and recruit consenting students who attended the workshops (Appendix E). The UNEC application was submitted to the Assistant Dean Undergraduate Nursing Program. The study was also submitted for approval to the McMaster Research Ethics Board.

Following approval by HiREB and UNEC, the Educational Research Assistant and Student Organizer associated with the SICG workshops contacted workshop participants and asked if they would agree to be contacted to hear about this study. Those who were interested were provided with the student researcher's contact details (Appendix F). Interested participants were subsequently contacted by the student researcher via an introductory email outlining the study (Appendix G). The email directed students to contact the student researcher by phone or email if they were interested in hearing more about the study and possibly participating. Study information was shared directly with participants. Interested participants were contacted by the researcher and a time and date was established for a one-time audio recorded interview at the site of their choice. Participants were offered a $10 Tim Horton's gift card as a gesture of gratitude for their participation. Participants were instructed that even if they chose to withdraw from the study, they could keep the gift card.

Data Collection

In a qualitative descriptive study, data collection is about "asking, watching, and reviewing" (Merriam & Tisdell, 2016, p. 105). Data was corroborated through data triangulation which involves using multiple methods of data collection to explore a phenomenon (Creswell, 2013). In this study, data triangulation included collecting a pre-interview survey, semi-structured interviews and field notes from the SICG workshop and individual interviews.

Semi-structured interviews. In-depth, semi-structured interviews were conducted with fourth year undergraduate nursing students between March 2019 and May 2019. One-on-one interviews were conducted to accommodate and respect the needs of those participants in the collection of their rich experience, as not all study participants are willing to share experiences in a group setting (Cresswell, 2016). The interviews were audio-recorded and then transcribed by the researcher. Participants were offered to meet in a neutral and private location of their preference. All participants chose to have their interviews at McMaster University in a private room. Open-ended questions were asked following an interview guide (Appendix H). The interviewer facilitated exploring the phenomenon naturally, moving beyond the set interview guide when appropriate as a way of fully exploring participants' experiences. Merriam and Tisdell (2016) recommend the use of a set of probes and trigger questions that can help get conversations started and keep interviews on track with the purpose of the study. To address this, Thorne (2016) suggests making connections between interviews by introducing a wider data. Throughout the data collection period, anonymous comments and concepts from previous interviews were brought up when appropriate for participants' thoughts on those concepts. Thorne (2016) however cautions that in order to enhance the quality of interview data, the researcher should engage in interviews with a "strong consciousness of what has been told [to us], on the basis of what conditions and prompts [we] have created for the interview, and with a thoughtful awareness of the broader social ideational context within which those interviews are conducted" (p.139). The amount of time allotted to the interview was also an important consideration, as it is important for the researcher to be present during the interview for the amount of time it takes to unfold (Thorne, 2016). Each interview lasted between 25-63 minutes in length, and additional time was allotted if required by the participant to fully describe their experiences.

Participant demographics were collected prior to the interview. Students were asked to complete a short questionnaire with questions about age, gender, professional practice experience, and perceived level of confidence related to components of the SICG (Appendix I). Participants were also asked if they had completed a training program focusing on palliative care or communication skills prior to attending the SICG workshop.

Critical incident technique (CIT). Critical incident technique was used to elicit participant accounts of engaging in serious illness communication at their professional practice placements (Flanagan, 1954). CIT is a method of data collection that seeks to collect specific incidents regarding the phenomena of interest and has been found to be particularly useful in exploring dimensions of nurse-patient interactions (Kemppainen, 2000). Flanagan (1954) describes an incident as “any observable human activity that is sufficiently complete in itself to permit inferences and predictions to be made about the person performing the act” (p.1). The term ‘critical’ is used to describe an incident with a clear intent and definite outcomes (Flanagan, 1954).

The aim of CIT is to summarize relevant facts and remove any personal opinions, judgements or generalizations from the incident (Flanagan, 1954). Critical incidents should include a description of a situation that led to the incident, the actions or behaviours of the primary individuals involved in the incident, and the resultant outcomes of these actions or behaviours (Kemppainen, 2000). When collecting critical incidents, Flanagan (1954) suggests having participants recall incidents that are fairly recent. In this study, participants were asked to describe specific incidents where they had (and/or recognized a need for) a serious illness conversation with a patient or the patient’s family member occurring in the last three months during their final practicum placement and following the SICG workshop. Participants were asked how they have used the SICG (or not) in their practice placement. They were also asked to recall a time when they engaged in a serious illness conversation with a patient or family and to reflect on that experience in relation to the SICG workshop. Lastly, participants were asked to recall any experiences when they did not engage in a serious illness conversation but recognized that it could have been helpful. CIT was selected to structure data collection because it aligns with the commitment of qualitative description to produce applied knowledge that can be used to address everyday practical problems (Kemppainen, 2000).

Observations. Thorne (2016) recommends the use of a reflexive journal to record personal reflections during the data collection and data analysis process. The student researcher attended the January 2019 SICG workshop. Supplementary field notes were written after the initial SICG workshop as well as after each interview. Maintaining a reflexive journal provided a space to record background preconceptions and ongoing analytical notes which facilitated reflexivity and strengthened rigor in the research process (Creswell, 2013). After each interview, a post-interview contact summary form was completed (Appendix J).

Data Analysis

Unlike other qualitative methods that attempt to interpret meaning or develop a theory through their analysis, qualitative descriptive studies result in a "rich, straight description of an experience or an event" (Neergaard et al., 2009, p. 2). The approach to data analysis used in qualitative descriptive studies is termed qualitative content analysis. It involves breaking down data into smaller units, coding and naming the units, and then clustering them based on similarities. Codes are derived from the data itself during the study. Both verbal and visual data is collected and then the informational content of that data is summarized (Sandelowski, 2000).

Early analysis began immediately following each interview through completion of a post-interview contact summary form, journaling and handwritten field notes. Reflective journaling and maintaining field notes added supplemental insight to the interview data (Patton, 2015). After each interview, the student researcher listened to its content and transcribed it word by word. Then, the transcript was read line by line by the student researcher and supervisor, and meaning units were identified and coded with labels. Codes with conceptual similarities were grouped into subcategories or dimensions. Similarly, subcategories with conceptual similarities were grouped with each other to form main themes.

Data analysis followed an inductive approach which involved working with the data until new understandings, explanations or concepts surrounding the phenomenon were generated (Patton, 2015). The data analysis process was reflective, with full immersion in the data through listening to the audio-recordings, transcribing the interviews, and rereading the transcripts. After the first two interviews, a code book was developed to reflect emerging themes and trends that appeared in the interviews. The code book was developed in consultation with the supervisor and the supervisory committee. The supervisory committee members hold expertise in various areas including serious illness care, palliative care, and undergraduate education. Investigator triangulation allowed for different perspectives and reduced the chance of investigator bias (Patton, 2015). Furthermore, Creswell (2013) describes that investigator triangulation can help the researcher go beyond their own direct observations of the collected data, and as a result provide new insights.

Rigor

The study used strategies to promote trustworthiness and enhance rigor based on Lincoln and Guba's (1985) seminal criteria. These criteria were used as their philosophical roots in naturalistic inquiry reflect those in qualitative description (Sandelowski, 2000)

Credibility is the "truth value" of qualitative inquiry (Krefting, 1991). Several strategies were used to ensure credibility throughout the entire research process including triangulation, peer debriefing, and member checks. Triangulation involves incorporating multiple perceptions to ensure repeatability of an observation or interpretation (Patton, 2015). Method triangulation was used in this study as data was collected through individual interviews, surveys and field notes. Investigator triangulation occurred through the involvement of the supervisory committee. They provided multiple observations and conclusions which were particularly useful during the data analysis and coding process. Having multiple researchers assist with coding of data supports truth value by ensuring the codes generated are present in the data (Patton, 2015). Furthermore, investigator triangulation added breadth and depth to the phenomenon of interest as members of the supervisory committee have in-depth knowledge of undergraduate nursing education and experience in serious illness communication research.

Participants were treated as experts of the phenomenon throughout the research process. Clarification and summarizing were used to support the developing understanding of each participant’s experience (Thorne, 2016). At the end of the interviews, researchers summarized the discussion, and asked for any additional feedback that participants wished to make.

Transferability is the usefulness of study findings in the context for which they are intended, and the ability to generalize study findings to larger populations (Krefting, 1991). A thorough description of the participants and the study setting is presented in the study findings. The use of a purposive sample in this study helped to ensure transferability as it ensured that participants’ individual experiences could contribute to a shared understanding of fourth year undergraduate nursing students’ experience of serious illness communication in their professional practice placements.

Dependability is the reliability and repeatability of findings (Morse, 2015). The use of method, data source, and investigator triangulation described previously was useful in ensuring that dependability was achieved in the study’s findings. Some variability may occur in the findings due to the fact that qualitative research looks at the range of experience rather than the average experience. As a result, variable experiences may be reported in the findings that may not be replicated in a similar study (Krefting, 1991).

Maintaining an audit trail that makes research detectable throughout the research process is important for ensuring both dependability and confirmability (Morse, 2015). When study findings are grounded in the experiences of the participants and not in the investigator's motivations and biases they are considered confirmable (Lincoln & Guba, 1985). Reflexivity is also essential in the process of achieving confirmability. Reflexivity is an understanding of the role of self in the process of creating new knowledge. This ensures transparency is evident in every step of the research decision making process (Berger, 2015). A reflexive journal was maintained throughout the entire research process to ensure that methodological decisions and reflections were captured.

Ethical Considerations

Ethics approval for the proposed study was obtained through the Hamilton Integrated Research Ethics Board (HiREB, Reference #: 5813). Additionally, all research studies that intend to use students enrolled in the undergraduate nursing program at McMaster University require approval of the UNEC. Approval was obtained by applying tothe Assistant Dean of the School of Nursing at McMaster University. This process ensured that that specific student target populations were not being overburdened by requests to participate in research.

Ethical issues may arise in every phase of the research process and must be addressed appropriately (Creswell, 2013). Protecting the confidentiality and anonymity of participants was considered a priority during the entire research process. Any information obtained in connection with the study that could have identified the participants and the patients they cared for remained confidential and anonymous. As the focus of this study is to describe the shared experiences of all participants, it is unlikely that specific personal experiences could be identified in the report. In addition, participants' individual experiences, opinions or comments from the interviews were not shared with any faculty members at the university. Demographic information, audiotapes, transcribed interviews and field notes were assigned an identification code and pseudonym and kept in a locked filing cabinet. Any digital data was stored in a password-protected computer. Only the student investigator and study supervisor have access to the information. An archive of data, with no identifying information will be kept for three years after the study conclusion for possible secondary analysis or research audit.

Informed consent is of particular importance in qualitative inquiry (Loiselle, 2011). As the focus of qualitative research is subjective human experience, it is difficult to predict what will occur in the research encounter. The goal of informed consent then is to create through verbal and nonverbal behaviours a space where participants share only what they feel comfortable sharing (Thorne, 2016). Each participant was given an informed consent letter based on the guidelines of the HiREB that outlined the research goals and purpose, participant recruitment process, type of data collection and collection procedures, potential risks and benefits of participation, length of the study, participant time commitment, and how the data will be used (Appendix K). The informed consent letter also emphasized how confidentiality would be maintained throughout the study and participants' right to withdraw from the study at any time. Another important aspect of informed consent that was considered in this study was ensuring that consent was continually negotiated throughout the research process. If during discussion in the interview, a participant felt that they were disclosing too much information, continually negotiating consent allowed the participant to pause to consider if they wanted to continue with the disclosure. Consent included each participant understanding that they had the right to pass on a question and halt the recording of information at any time. A $10 gift card to Tim Hortons was provided to participants at the start of the interview. This amount in no way suggested coercion of participants and was rather a small gesture of gratitude for their participation.

It is unlikely that the study directly benefited participants. However, it may have been therapeutic for participants to discuss their experiences of engaging in serious illness communication in a safe, non-judgmental environment. Reflecting on their experiences may have deepened participants' understanding about their own practice and the intentional use of the SICG. The results of this study may lead to improvement in education and the development of additional supports for nursing students in their clinical placements. Although it is also unlikely that participants experienced any harm or discomfort during the study, serious illness communication can involve the topics of death and dying which are sensitive topics of discussion and warrant particular ethical considerations (Anderson et al., 2015). Participants were not required to answer any questions that they did not want to or that made them feel uncomfortable. Furthermore, participants were advised that they could stop to take a break at any time during the interview and that they could stop taking part in the study at any time. At the conclusion of the interviews, all participants were asked if there was anything else that they wanted to discuss. All participants were given a list of supports and resources they could access at any time if they felt they needed to talk to someone further about their experiences. McMaster University has free counselling offered to all undergraduate students. Additional community resources and services that participants could access were also provided.

CHAPTER 5: FINDINGS

This chapter describes the findings related to the experiences and engagement in serious illness communication of fourth year undergraduate nursing students who have participated in SICG training. This chapter begins with the participant demographic characteristics related to students' education and professional practice placements, and then describes the study findings including the major themes and dimensions. Direct quotes of participants are included in the findings to support description of the themes. The results will be described in two separate parts, the first relating to nursing students' experiences engaging in serious illness communication and the second relating to nursing students' perceptions of the SICG workshop.

Participant Demographics

A total of eight participants participated in a one-on-one semi-structured interview exploring their perceptions about the relevance of the SICG training to their practice and to discover if and how they implemented the SICG training in their practice settings. The study participants ranged in age from 21 to 24 years old (mean: 22.3; SD: 1.2). Most participants were female (n=6, 75%) and the majority had entered the nursing program after high school (n=6, 75%). Two participants (25%) had obtained a Bachelor of Science degree prior to entering the nursing program. There was variety in the participants' Level 4 professional practice placements, including placements in mental health, pediatrics, and critical care. Only one participant had previous related volunteer experience in relation to serious illness communication. No participants had any palliative care or communication training before the SICG workshop (Table 1).

Table 1: Participant Demographics

Characteristics	N (%)
Age in years [Mean (SD)]	22.3 (1.2)
21	2 (25%)
22	4 (50%)
23	0 (0%)
24	2 (25%)
Gender	
Female	6 (75%)
Male	2 (25%)
Previous education	
High school diploma	6 (75%)
BSc	2 (25%)
Palliative care/communication training	
Yes	0 (0%)
No	8 (100%)
Related volunteer/work experience	
Yes	1 (12.5%)
No	7 (87.5%)
NK10 placement	
Seniors mental health	1 (12.5%)
NICU*	1 (12.5%)
ICU	1 (12.5%)
Acute medicine	1 (12.5%)
Psychiatric emergency	1 (12.5%)
LTC	1 (12.5%)
Adult oncology	1 (12.5%)
Community clinic	1 (12.5%)
Previous Level 4 placement	
Surgical	1 (12.5%)
Community clinic	1 (12.5%)
Acute medicine	2 (25%)
PACU	1 (12.5%)
Complex care	1 (12.5%)
Cardiac critical care	1 (12.5%)
Global health	1 (12.5%)

**Note.* NICU- Neonatal intensive care unit, ICU- Intensive care unit, LTC- Long term care, PACU- Post-Anesthetic Care Unit

Prior to the interviews, participants scored their current perceived level of confidence related to each of the seven components of the SICG (Table 2). Participants' mean confidence score across all seven components combined was 4.6 (SD=0.6) which fell between neither 'confident nor unconfident' and 'somewhat confident'. The three components for which the participants had the lowest scores were allowing silence (M=4.0, SD=2.0), exploring trade-offs (M=4.0, SD=0.8), and sharing information about the future (M=4.1, SD=1.1). Participants had the most confidence in two SICG components: exploring goals (M=6.0, SD=0.8)) and exploring fears and worries (M=5.4, SD=1.1).

Table 2: Participant confidence in using components of SICG

Components of SICG	Mean confidence score* (SD)
Setting up conversation	4.6 (1.3)
Assessing illness understanding	4.8 (1.4)
Sharing information about future	4.1 (1.1)
Allowing silence	4.0 (2.0)
Exploring emotion	5.1 (1.5)
Exploring goals	6.0 (0.8)
Exploring fears and worries	5.4 (1.1)
Exploring sources of strength	5.3 (1.3)
Exploring critical abilities	4.6 (0.7)
Exploring trade-offs	4.0 (0.8)
Documenting conversations	4.4 (2.0)
Communicating with key clinicians	4.6 (1.9)

**Note.* Extremely confident (7) Very confident (6) Somewhat confident (5) Neither confident nor unconfident (4) Somewhat unconfident (3) Very unconfident (2) Extremely unconfident (1)

During the individual interviews, participants described between two to five critical incidents each, which are factual descriptions of observed incidents involving human behaviour (Flanagan, 1954). A total of 27 critical incidents were identified in the data, only nine of which occurred following the SICG workshop. Due to a large diversity in participants' current and previous professional practice placements, the critical incidents collected had widely varying contexts (Appendix L). Most of the critical incidents described both pre- and post-workshop involved participants engaging in a serious illness conversation with a seriously ill patient's family member, rather than the patient. This may have been due to the acuity level of the professional practice placements and the poor medical condition of the patient population that participants described. Most commonly, the serious illness conversations described within the critical incidents were with family members and related to a patient who was imminently dying, and not geared around future planning in the way that the SICG content was intended.

Part I: Nursing Students' Experiences Engaging in Serious Illness Conversations

Only three participants described situations where they engaged in a serious illness conversation in its entirety at one moment in time, using all seven steps prescribed in the SICG. The majority of participants had placements in a hospital setting (75%) and they perceived these settings were not necessarily conducive to having what they believed to be a long, uninterrupted conversation with patients and their families. Instead, many participants described employing parts of the SICG during moments of care. In this analysis, the term "serious illness talk" will be used to describe any application of any part of the SICG that participants used to have a conversation regarding patient's wishes, preferences and future illness planning.

Three themes were identified regarding the ways in which participants engaged in serious illness conversations in their professional practice. These were: 1) Serious illness communication is challenging to enact, 2) Finding moral and ethical ground, and 3) Fitting into the culture of the professional practice setting. Several dimensions identified in the data characterized each of the three major themes. See Table 3 for a list of themes and dimensions related to nursing students' experiences of engaging in serious illness communication in practice settings.

Table 3. Thematic Dimensions of Nursing Students' Experiences Engaging in Serious Illness Conversations

Themes	**Dimensions**
1. Serious illness communication is challenging to enact	a) "*Opening the door*" b) Building a *"good foundation"* through serious illness conversations *c)* Navigating through a *"rollercoaster of emotions"* d) Allowing for silence: *"I could have probably left more space for silence"* e) Embedded in care: "*you never know when someone is going to want to talk"*
2. Finding moral and ethical ground	*a)* Experiencing moral distress as a nursing student: *"It keeps coming back to my mind"* b) Taking responsibility to have a serious illness conversation: *"I knew I had to do something with that information"* c) Managing tension between truth-telling and false hope: *"you're going to get better"*.
3. Fitting into the culture of the professional practice setting	a) Influence of professional practice setting norms: *"that's just how it is here"* b) Role modelling and support in clinical practice: *"she let me do it"* c) Looking for validation and permission *"I'm not sure if that's my place"* d) Nursing students' professional self-identity: *"I'm a student but I'm going to be an RN* e) Needing a palliative label: *"there was so much uncertainty"*

Theme One: Serious illness communication is challenging to enact

Participants found serious illness communication to be challenging to enact due to their perceptions about their role as nursing students', and the 'serious' nature of the conversation. Despite their enthusiasm for the SICG, their willingness to learn and attempt to use it, participants continued to find serious illness communication to be a very challenging relational practice. In their accounts of serious illness communication experiences, participants described that they questioned their role as a nursing student, lacked confidence and were hesitant when attempting to engage in any serious illness talk. Participants described being unsure at times about whether the things they were saying were helpful and meaningful to the patient and their family. Regardless of their uncertainty and lack of confidence at times, they also described thinking more deeply when they were engaging in communication after they had participated in the SICG training. All participants said that the SICG training had impacted their practice by making them more thoughtful about patient's serious illness communication needs and helped them to be better able to recognize cues related to these needs. Furthermore, participants had a greater understanding of their professional obligation to patients and families to have conversations around future planning, even if they didn't always feel confident acting on these obligations. The dimensions that characterized the challenging nature of serious illness communication were: a) "opening the door", b) building a "good foundation" through serious illness conversations, c) navigating through a "rollercoaster of emotions", d) using silence, and e) embedded in care.

"Opening the door". In the pre-interview survey, the majority of participants indicated they were "somewhat confident" with "setting up the conversation", the first SICG component. Yet during the subsequent interviews, they shared experiences that indicated their continued discomfort with serious illness conversations and their perceptions that nursing students were not permitted to have these conversations. Following SICG training, participants' perspectives and experiences indicated that they felt more skilled and comfortable in “setting up the conversation”, although they still questioned their role in initiating serious illness conversations and as a result often hesitated to do so:

> As nursing students, we very much feel like students and you constantly question yourself. ‘Is it my place to have this conversation?’, ‘I'm just a student, I don't know anything’. And you think maybe you should leave it to someone more experienced because you're just a student and it's not your role. (P-05)

Participants recognized that patients' and families' specific care-related questions often presented opportunities for the participant to use parts of the SICG and engage in serious illness talk; only three participants identified using the SICG in its entirety. This insight encouraged them to take the conversation further than just responding to the care-related question asked of them, and into a discussion about future illness. For instance, a participant in a critical care setting described how they developed a trusting and open relationship with a patient's family over time. As a result of this relationship and the participant's knowledge of the SICG, they were able to respond to a family's care-related question in a way that opened the door to deeper dialogue about the implications of the patient's illness and prognosis:

> Well I can remember one specific conversation where the family asked me what the blood work results were and what they meant and I broke down the information for them in a way they could understand and I related the information back to the disease process and what was expected at this point. This conversation ended up opening the door to them asking about what the prognosis looked like for her which was a difficult conversation. (P-03)

Exposure to the SICG and training stimulated participants to think more about the care-related questions that patients asked. Furthermore, it raised participants' consciousness about the need for serious illness communication and the cues related to these needs, although they weren't always sure how to respond to the cues.

Building a "good foundation" through serious illness conversations. Across professional practice contexts, participants related the ways in which the SICG gave them a framework that allowed them to further develop therapeutic relationships with patients and their families. Most participants assumed that patients lived with a serious illness for a long period of time which would have resulted in multiple opportunities to have serious illness conversations with their health care providers, yet that was not always true. After receiving SICG training, participants saw added value in establishing a relationship with patients and their families; that it could set a positive foundation for conversations in the future in regard to serious illness and its implications. A participant in a critical care setting described how using the SICG's "patient-tested language" to structure the conversation allowed them to create a "foundation" that they could continue to "build on" in future conversations:

> I asked the family several times actually at different points, "what do you understand about what's happening right now and the situation", "what are your expectations for treatment?". I think they're great questions because you find gaps and you also find strengths so it's good. We had many conversations that were continuous so I mean it gives you a good foundation to build on in future conversations and decision making. (P-03)

Furthermore, the participant recognized that engaging in serious illness talk helped to ensure that patients received continuous care that aligned with their values, beliefs, and goals of care: “I find that these [serious illness] conversations help you build a good relationship with families, there’s this continuity of care that I think is really important” (P-03). Having the SICG knowledge made it possible for the participants to engage in serious illness talk, and to ask the appropriate questions that supported a therapeutic relationship with patients and their families. However, one participant also related how easy it could be to get caught in accomplishing their daily “to-do list”, and dismiss patient initiated cues that indicate a need for serious illness talk:

> To that patient, that to-do list is not important. Getting the emotional validation and the support they need for something difficult that they’re going through is what’s important. You can get the stuff you need later, what’s important is understanding what’s important to them first. I think that helped the conversation along because it made her more comfortable to share more. She felt like I wasn’t dismissing what she was saying. (P-05)

In the conversation to which the participant refers, taking the time to understand the patient’s unique context and validating the patient’s feelings helped to create an environment that was emotionally comfortable for the patient. This environment facilitated dialogue that ultimately supported a more therapeutic relationship to develop between the participant and the patient.

Participants claimed that the SICG gave them the confidence to initiate serious illness talk because the guide provided concrete steps and dialogue to follow. One participant described a situation where they drew on the SICG to engage in serious illness talk effectively. The participant was working with a wound care nurse and they had a patient that was at the end-of-life but the family hadn’t been made aware of the patient’s change in status. The participant asked many questions to gain an understanding of the patient’s situation and then used the SICG to have a conversation with the patient’s daughter:

> With the [SICG] workshop, it gives you more concrete things to draw from…I did not know this lady. I had met her on one occasion beforehand. But I was connected to the situation. Having an understanding of the situation was the biggest thing. It’s hard to launch into the conversation if you don’t know that person’s story. (P-06)

This example reflected others’ descriptions about how the SICG training offered them knowledge and language to ask appropriate questions that could lead to an understanding and a connection to the patient and their story.

Navigating through a “rollercoaster of emotions”. Addressing patients’ and families’ emotions was regarded by participants as a challenging part of engaging in serious illness communication. They acknowledged that there were many dynamic influences that occurred during serious illness talk and these influences often lead to what participants perceived to be an unpredictable emotional response from patients and their families. Most participants found it difficult to read the emotional responses of others and felt unprepared to manage emotional upset they imagined that could result for patients and their families. Participants perceived that the serious illness conversation went well when patients and/or their families were receptive to the information being shared with them. The following quote reflects the sense of relief about not having to respond to patient’s and family’s emotional expression:

> The family and the patient's receptiveness to the conversation was good, and that's probably why the emotions didn't make me uncomfortable. There was nothing really negative or drastic. No one had a meltdown or anything ... like crying outbursts or anything like that, where I would have felt a little more unsure of how to deal with it. (P-08)

In this example, the language the participant chose to use when describing the patient and family’s emotions suggested their need to feel in control of potential responses the patient and or family might have when engaging in the serious illness conversation. A sense of control was achieved when the participant perceived the patient and family’s emotional response was “appropriate”, or that they reacted in a way that the participant felt was the correct emotional response given the situation. Although the patient didn’t have an “outburst” and appeared to accept the situation, it is possible that they may not have felt comfortable enough to express their fears or concerns. The participant did not acknowledge the possibility of having missed or misread important cues related to the patient’s serious illness communication needs. They also did not acknowledge the possibility that they may have been sending cues to the patient and their family that discouraged emotional expression.

Although participants recognized that patients’ and family’s emotional responses to serious illness communication could be unpredictable, they still expressed their expectations and assumptions about what they considered to be the appropriate emotional response from patients and their families. These unspoken assumptions and judgements affected the participant’s willingness to invest in serious illness talk; they were more comfortable when they perceived patients and their families did not require much emotional support from their healthcare providers. In another instance, a family member was described by a participant as “reasonable” during a serious illness conversation they observed between a doctor and the family member. The participant described their observations in regard to the family member’s emotional response: “I remember listening in on a small part of the conversation the daughter had with the doctor and she [the daughter] was really reasonable. She seemed to understand why he [her father] was at this stage [of illness] and what this meant” (P-04). Another participant described a family's emotional journey through a patient's fluctuating condition over time which caused the family to be upset and react very emotionally. Despite making assumptions about how "emotional" or "sad" the patient's family should be given the circumstances, the participant demonstrated very little awareness of these assumptions:

> It was unfortunate for the family-that rollercoaster of emotions because you could tell they were reaching for any sort of hope. So hearing bad news, bad news, bad news, and a little bit of good news, and they were like very excited, and then again bad news, bad news, bad news. Other than that they were pretty understanding of the situation and they were sad for sure but I've definitely seen other more emotional patients. (P-03)

The situation reflects the expectations that the participant held about how people should react emotionally in certain situations. There is a sense of desensitization demonstrated in the participant's narrative that indicates a lack of insight in regard to the family's experience and the level of support that might be needed in relation to that.

When participants' described situations where patients or their families were very distressed or emotional, they reported feeling a lack of confidence and uncertainty about whether or how to engage in serious illness talk. One participant reflected on a situation that occurred prior to the SICG workshop where they felt completely unsure about how to respond to a patient's emotional response:

> I just stood there awkwardly in silence while he cried because I didn't know what else to do. I held her hand because she was crying and freaking out and didn't know what to do…Yeah, I had no idea what to say. I was just kind of standing there because my preceptor went to go get all the stuff to deal with the reaction and he was like, "just stay

> here with her." So I was staying there trying to keep her calm because she was freaking out and then he was crying and I didn't know what to do. (P-07)

The language used by the participant indicates that they found managing the patient’s upset emotions to be challenging. The participant described the situation as awkward and acknowledged feeling uncertain of the appropriate response to the patient’s emotions, yet the actual actions they undertook may have been helpful to the patient. The participant described staying with the patient and attempting to provide a sense of presence and comfort. This in reality may have been the only thing that anyone could have done, but the student still felt unprepared. Post-workshop they expressed feeling more comfortable to respond if they were placed in a similar situation due to their increase in knowledge and experience.

Allowing for silence: “I could have probably left more space for silence”. The topic of silence was raised by the majority of participants during the interviews. After learning about the use of silence as a therapeutic intervention during the SICG training, they demonstrated a new valuing and appreciation of silence but still struggled to incorporate the skill into their practice. For instance, one participant described feeling inexperienced in responding to emotionally challenging situations but post-workshop, recognized that the use of silence could have been useful:

> I felt like I could have probably left more space for silence. He kept asking me, "what are you going to do? What are you going to do? What are you going to do?" And I'm like, "I don't know what I'm going to do. I'm a fourth-year student. I haven't done this before." (P-07)

The situation reflected the participant’s feelings of uncertainty during an emotionally charged situation and a sense of uneasiness with using silence as a way of providing presence to a patient’s family member in distress. Although the participant expressed feelings of defeat related to their actions during the interaction, they recognized the important role that silence could play in relieving tensions and allowing space for reflection and processing of feelings.

Participants perceived that by allowing for silence, they were in essence “doing nothing” to help their patients during a time of need. Even after receiving the SICG training and knowing that silence was an appropriate therapeutic intervention during a serious illness conversation, participants were still hesitant to incorporate it into their practice. One participant seemed to conflate silence with nothingness or a void and reported feeling awkward and uncomfortable when allowing for silence:

> Some of the parts that are a little harder for me are things like allowing for silence. I feel like I always need to keep talking, I can’t just be sitting there staring at my patient, that’s weird. That’s been one of the things I’ve been working on. (P-05)

Despite feeling uneasy with the idea of allowing for silence during an interaction with a patient, the participant ultimately acknowledged that intentional silence could be an important facilitator in building a therapeutic relationship and expresses an interest in continuing to develop and gain comfort in the skill.

When participants reported that a serious illness conversation did go well, they usually attributed their use of silence and presence as conversation facilitators. One participant reflected on a conversation that they felt had been successful: “What facilitated the conversation were the components like the silence, the wait, and listening to her” (P-06). The participant recognized that the intentional use of silence was linked to actively listening to the patient and could create opportunity for further dialogue.

Embedded in care: "You never know when someone is going to want to talk". Participants described many serious illness communication opportunities that occurred informally, embedded in moments of care, and not in designated family meeting times. The situations they recounted involved a patient or family member initiating a serious illness conversation during an informal moment of care, rather than the participant initiating one. A participant reflected on how opportunities for serious illness conversation most often presented themselves spontaneously and during unexpected moments during care:

> Even sometimes I find you'll walk into a room, like say you were just answering a call bell and all of a sudden, this person may be telling you all these things you have no idea how to answer. You never know when someone is going to want to talk or say something like that. And you don't want to walk away from it but that may not even be your patient or your assignment. Then you'll never know if the conversation has a chance to happen. (P-02)

This participant expressed hesitancy to engage in a serious illness conversation as a nursing student, and was uncertain about how to respond when serious illness communication opportunities were unexpectedly initiated by patients and their families.

Although serious illness conversation opportunities presented themselves during informal moments of care both pre- and post SICG training, participants said that the training allowed them to create practice conditions where patients and families felt safe to talk and engage in a serious illness conversation. One participant described how she engaged in a serious illness conversation after a family member initiated a conversation with her while she was providing care to the patient. The participant was able to relieve some of the family member's distress by addressing the son's concerns and answering his questions openly and honestly:

> I was in the room doing something basic, like taking blood pressure, or something like that. The son just kind of started talking, and asking questions, and sort of saying to me like, ‘Yeah, I don't think the prognosis looks good’. (P-08)

One participant described a situation pre-workshop where they had the opportunity to observe a wound care nurse engage in a serious illness conversation while providing wound care to a patient. The nurse had no established relationship with the patient, yet she responded to the patient’s concerns directly and without hesitation. This situation was regarded by the participant as a positive example of role modeling about how serious illness conversations could be integrated into the provision of care and not as an isolated conversation:

> I was shadowing the wound care nurse …we went in to see this one patient who had recently had a below the knee amputation because of her diabetes…we were looking at her wound and it was bad… the woman all of a sudden in her bright affect starts crying and she turns to the wound care nurse and she’s like “Am I going to lose my knee?”And I was shocked, so I kind of stepped back. But the wound care nurse didn’t shy away and she had this whole conversation with her about what as important to her and asked about her fears and her goals. She outlined the choices she had and then asked her about her preferences. She asked “I want you to keep your knee but if you weren’t able to how would we handle that?” It really helped the patient which I thought was great and it was a really good example to me of how to tackle these difficult conversations. She was very respectful with the patient which I liked. As a wound care nurse it’s hard cause you’re not seeing this patient all the time so you can’t build a whole therapeutic relationship with each patient you’re seeing but she was still able to effectively have this difficult conversation with her. (P-05)

The nurse in this situation took the opportunity to explore the patient's preferences and was able to simplify complex medical information and frame the choices that the patient had to make in a way that was understandable. This respect for patient autonomy was viewed as positive and helpful role modelling by the participant.

Theme Two: Finding moral and ethical ground

Prior to the SICG workshop, most participants had experienced a "didn't feel right" incident about a patient's care trajectory, where they knew something was wrong but they couldn't label the source of their psychological discomfort. In retrospect, they sensed a need for a serious illness conversation, but didn't have the knowledge, confidence or skills to have such a conversation. When they did engage in serious illness talk, participants often described their use of excessive optimism and false hope as a way of maintaining hope when a patient had a poor prognosis. These ethically challenging communication experiences in the clinical setting related to serious illness communication led participants to experience inner conflict. After attending the SICG workshop, participants said they had more knowledge and language that helped them better approach these situations. They said they were more able to recognize the source of their discomfort and to articulate it. The dimensions of this theme were: a) experiencing moral distress as a nursing student, b) taking responsibility to have a serious illness conversation, c) managing tension between truth-telling and false hope.

Experiencing moral distress as a nursing student: "It keeps coming back to my mind". Participants' accounts of their experiences pre- and post SICG training uncovered patterns of moral distress and revealed that moral distress was a prominent aspect of practice as a nursing student, particularly in the context of serious illness conversations. Moral distress was expressed as a reaction to an ethical conflict and occurred when participants felt that they were unable to act in a way that they felt was ethical or appropriate due to their professional practice environment or perceived confidence and skill engaging in a serious illness conversation.

In the ethically complex clinical scenarios that participants described, they recognized times when a serious illness conversation needed to occur yet they were uncomfortable or lacked the knowledge and skill to initiate and engage. A participant recalled a situation that occurred in a professional practice placement over a year prior to the SICG training, where they sensed an opportunity for what they now understood was a serious illness conversation but felt that they lacked comfort with the skill, and uncertainty about their role as a nursing student:

> I remember one particular patient who had recurring UTI's and urosepsis, Type 2 diabetes, terrible peripheral neuropathy. Just a very sad case, he was in his 40s. He expressed all the time that he just wanted to die and his family was definitely clinging on to hope. They would say "you need to push through this" "you're going to get better". But in reality no. And I just felt like something had to be said but I didn't because I definitely felt like it was outside my comfort zone, I also felt it was outside of my scope of practice as a student. (P-03)

The participant's perception of their role as a nursing student made them feel like they were in a powerless position and impaired their ability to advocate for the needs and wishes of their patient. In this situation both the patient and their family may have been unaware of the true prognosis and trajectory of the patient's serious illness. This participant's discomfort and uncertainty led them to avoid entering the discussion, leaving them with heightened feelings of moral distress.

A number of the clinical scenarios that participants referenced, related to experiences in which they perceived that they ought to have been able to do more. A participant described a morally distressing situation pre-workshop that they continued to be reminded of over a year later:

> I wish I had maybe probed more, maybe asked her if she's had a chance to talk to someone about these feelings that she was describing to me. She probably would've taken the opportunity. I don't know if this particular conversation I had with her was her breaking point or what but it seemed to be. I'm thinking of this situation specifically because I even thought about it before when doing the serious illness workshop. It keeps coming back to my mind for some reason, it's just one of those situations where you really feel like a serious illness conversation could have been helpful. I'm sure I've had other experiences but this one just really stuck with me and I always think back to it. (P-02)

In this situation, the participant saw an opportunity to engage the patient in a serious illness conversation but didn't act on that opportunity. The participant's account of the experience reflected feelings of regret and a sense of blaming oneself. The experience was evidently morally distressing to the participant as they continued to think back to the situation regularly.

Another context that triggered moral distress in participants was the difficulty navigating responsibility for serious illness conversations associated with delivering "bad news". For instance, a participant described a morally distressing situation pre-workshop where they remembered feeling upset. They described the particular conversation as their first experience with having a "bad news conversation":

> It wasn't the patient, it was the son, [who] was super distraught about it. I remember I was thinking, "I don't even know what to say to comfort you, or suggest. I don't know enough

> about your dad, and his history, and his prognosis currently." I knew it wasn't good. I knew he would never recover. I remember that was probably the first exposure I had to ... a bad news conversation that I remember being pretty upset leaving clinical that day I was like, "Ugh, I don't feel like I was helpful. I don't really feel like I had a lot to say. I don't feel like I was very comforting." So I felt like that was probably my first encounter with it. (P-08)

The participant in this situation was not only tasked with relaying prognostic information to the patient’s son and managing his feelings of distress but also had to handle their own emotions. On reflection, and knowing about serious illness conversations, the participant realized that the situation was missing a deeper dialogue. At the time of the conversation, the participant didn’t perceive they had the knowledge or skills to undertake having a bad news conversation effectively, which likely had negative emotional consequences for the patient’s son and for the participant.

Participants also noted that the culture of professional practice placements acted as a barrier for students to engage in serious illness conversations. Participants described certain placements where they assumed that the healthcare team did not value such conversations, and engaging in them was simply not an accepted part of the culture of the setting. In particular, participants in more acute environments found that the priority of those areas was more heavily focused on life-saving interventions. A participant described a pre-workshop situation on a surgical floor where they felt that a conversation should have been initiated but due to what they perceived as a lack of appropriate modelling and support from their preceptor, they chose not to say anything:

> There was a patient there who was a quadriplegic and in his mind he was going home. But we knew, and his family knew, that there was no way he was going to be able to go home. He was an older gentlemen, his wife was older as well. There was no way his wife was going to be able to do all that care for him at home. So he kept saying to my nurse and I "oh I'm excited to go home" and all that kinda stuff. And I think that's when someone should've said something. Maybe not like "no, you're not going home" but something about what his condition was and that he probably wasn't going home. It was kinda awkward, we just sort of left him like that. And then nothing was really followed up. No one ever said anything else about it, or passed it on. I felt that maybe I should've said something but we didn't. (P-01)

After attending the SICG workshop, participants described engaging in serious illness talk more effectively. Engaging in serious illness talk contributed to feeling they had met a patient's needs for information and that it had a positive impact on the patient's family:

> When I talked to the patient's family I kind of told them that we weren't sure what was going on but I kept them updated with any new intervention we tried or any new results that we got. I took it step by step as best as I could so they could follow all the craziness that was going on. We also talked about taking it day by day instead of figuring out everything at once because that wasn't possible in this situation. (P-04)

This participant acknowledged that they still weren't an expert in having serious illness conversations, but by using parts of the SICG they felt more comfortable engaging in serious illness talk and recognized opportunities for serious illness talk when answering patients' and families' questions. These attempts to engage in serious illness conversations were more satisfying for participants than prior to having the SICG training.

Participants provided many examples of situations in their professional practice placements that took an emotional toll on them. They attempted to develop effective coping strategies to be able to continue caring for patients with serious illness. They also described the various ways that they coped with the feelings that were evoked when caring for patients with serious illness. The importance of self-care in relation to this was captured by one participant who stated:

> That was my first taste of it. I was like, "Oh, nursing's hard some days!" That was a bit of a reality check. Not every day is ... you get a nice patient, you get a good news patients, things like that. I feel like in fourth year, it still takes an emotional toll. It's sad to see that, especially too, seeing family upset and whatnot, but I would say I have a better ability to reflect on it and handle it emotionally. Going home I was better at separating, "Okay, I had a hard day," but either letting that go, or doing something to distract myself, or going for a run, or going to the gym, or hanging out with someone, or a friend, or whatever. I feel like I got better at that in fourth year, just because I was more aware of it. Some days suck and that's kind of the way it is with any job. Probably more emotionally distressing with nursing. Third year, I feel like I wasn't super equipped to deal with any type of emotional distress. Fourth year, I felt a bit better, but some days still take a toll. I don't think there's any perfect prescription to walk away from a sad day like that, like not be somewhat affected by it. Better now, but some days are still hard. I do feel like there is that point where you go from thinking nurses help, and nurses make people feel better, and you kind of realize how hard and demanding the role really is. (P-08)

This participant had developed a plan for coping with morally distressing situations that they perceived as partially effective. However, they also perceived there was a lack of system level support for helping them to manage these situations. Although every participant described a morally distressing situation, none of the participants indicated that any form of debriefing or mentorship related to coping strategies had occurred from their preceptors or clinical instructors.

Taking responsibility to have a serious illness conversation: "I knew I had to do something with that information". Participants described facing multiple ethically challenging and morally distressing situations prior to attending the SICG workshop, as they didn't have the required knowledge and skills to engage in serious illness communication at that time. After attending the SICG workshop, participants described feeling a moral imperative, or sense of responsibility that lead them to attempt to engage in a serious illness conversation. A moral imperative was a strongly felt principle that led participants to act in various ways, most notably by attempting to engage in serious illness conversations with patients and their families. Although they continued to encounter ethically challenging situations, they now had an intervention they could undertake to attempt to meet the patient/family needs and thereby lessen their feelings of moral distress.

Oftentimes a sense of responsibility, rather than a long-established relationship was associated with participants initiating a serious illness conversation. For instance, post-workshop, a participant was placed on a Seniors Mental Health Unit and had the opportunity to care for a patient and their family for several months. However, they did not create the opportunity for serious illness communication and revealed that their conversations never went further than small talk: "So this was near the end of my placement and I had known both the mother and daughter for a couple months at this point. I hadn't really had a chance to talk to the daughter too much before this time though other than small talk" (P-01). In contrast, another participant had just been recently introduced to a patient and felt completely compelled to engage in a serious illness conversation with the patient’s daughter:

> I really felt for her. I felt really in it with her. I asked her what she really wanted to do and where do you want to go from here. I felt that we had connected. That was the craziest part. I felt we connected really quickly. It came from a place where I felt so badly for her. I felt a real sense of responsibility to tell her what could happen. I would hate to know if no one told me that my mother could pass away in a week. That would be horrible and traumatizing. (P-06)

These contrasting situations demonstrated that having a long-term relationship with patients and their families did not necessarily predict participants engaging in a serious illness conversation. It also challenges a common belief that serious illness conversations require a long-term relationship with the patient or family member.

A participant placed in a psychiatric emergency unit described how the SICG training created a sense of responsibility to both have a serious illness conversation and also to do “something” with the information as soon as they heard their patient’s story. The participant had just had their first encounter with this patient and certainly did not have an established relationship with her, yet they felt compelled to act after having a serious illness conversation:

> It was a little bit scary because I knew I had responsibility in that moment. I was the first person to hear that and so I knew I had to do something with that information. And this sounds a little bit egocentric but I felt like I was very important and that I was making a huge difference for her and I was really glad that I could do that. (P-05)

This participant demonstrated a sense of professional responsibility for initiating a serious illness conversation, which led them to establish an appropriate care plan for the patient.

Even after receiving the SICG training, participants still recognized that they tended to rely on “someone else” in the healthcare team to initiate a serious illness conversation. Although they knew that this would mean that necessary serious illness conversations and decision-making likely did not occur which ultimately had repercussions for the health of seriously ill patients and their families, this understanding did not always result in concrete action. A participant reflected on the lack of responsibility to have a serious illness conversation they saw in their professional practice placement:

> I think that if you don’t feel obligated to have these conversations you kinda just pass it onto someone else and just expect that someone else will take care of it. But if everyone expects someone else to do it then will the conversation ever happen? Who knows. (P-04)

The participant’s commentary on the general tendency of healthcare professionals to pass along responsibility to have serious illness conversations implies a lack of modelling in clinical practice that results in nursing students not feeling comfortable engaging in serious illness communication with patients and their families.

Managing tension between truth-telling and false hope: “you’re going to get better”. To maintain hope in a palliative context, participants found that they sometimes used false hope as a way of doing so. This led to ethical tension in participants’ practice as their desire to improve patient’s welfare by sustaining hope was often in conflict with their professional responsibility to tell patients and their families the truth. As a result of this ethical tension, participants found discussing prognosis to be an extremely challenging responsibility. When discussing prognosis, participants attempted to balance the desire to be hopeful, helpful and optimistic with the need to attend to serious illness communication and poor outcomes for patients. Several participants reported that before the workshop they had provided patients and their families with false hope as a way of responding to patient's apparent poor prognosis. For instance, a participant shared their experience pre-workshop as a third-year student placed on a medical floor. They described providing the patient with false hope as a way of managing their discomfort with the topic of prognosis:

> …listening to her say those things and not maybe understanding at this point that I was almost giving false hope now looking back. I said things like "oh you know, you're going to get better". Now looking back with the knowledge I have I can see that it's probably not what she needed at the time. I could've had a better conversation but I guess I just didn't wanna be too direct. I also didn't have a great understanding of what she had been told and I didn't really delve into that kinda stuff. I didn't know what her future was looking like and what else was going on right. I think listening was good but I just feel like I didn't know what to say and honestly I felt uncomfortable in the situation. I was telling her it was ok and I know that's probably not the best way to approach it. (P-02)

After reflecting on the experience, the participant was aware that the way they had engaged in the conversation was likely not as therapeutic as it could have been. The emotional discomfort they had experienced related to the conversation came across as ignoring the patient's concerns and false hope. After attending the SICG training, the participant had a new set of skills and knowledge on how to engage in a conversation related to prognosis. The participant learned that hope is a difficult construct in the context of serious illness and that their role as a healthcare provider is to help their patients and families reframe hope.

Even after attending the SICG training, some participants felt that when broaching the topic of prognosis, their good intentions came across as excessive optimism that overshadowed actual circumstance and patients' feelings related to their poor prognosis: "I'm always very positive about people's prognosis and I'm like 'they're going to get better, we can turn this ship around' even when they have a bad diagnosis and they're deteriorating" (P-04). Similarly, participants described using optimism as a way of protecting themselves and their patients from the reality of a poor prognosis. One participant described coping with a poor prognosis by maintaining positivity regardless of the actual circumstances: "I feel like sometimes I try to just throw a positive spin on things" (P-08). Ultimately, participants found it was very difficult to have serious illness conversations with patients and families experiencing serious illness and still maintain the sense of hope and caring that they intended to. These competing needs were ethically challenging for participants, and even after attending the SICG workshop, they recognized the need to learn how to better draw the line between navigating hope and giving patients and their families false expectations.

Theme Three: Fitting into the culture of the professional practice setting

Varying practice cultures were reported in the critical incidents which had an impact on how confident and comfortable participants felt engaging in serious illness communication. Each professional practice setting had its own practice patterns and norms and participants described a desire to fit into the culture of the placements that they were in. Organizational structure, the patient population, "taken-for-granted" knowledge and practices all appeared to shape the way that participants experienced engaging in SIC. For instance, participants described having placements in settings they perceived as not valuing serious illness communication. This in turn affected participants' willingness and confidence to engage in serious illness conversations. Even after receiving SICG training, these various influences related to practice culture affected participants' uptake of serious illness communication. The dimensions of this theme were: a) influence of professional practice setting norms, b) role modelling and support in clinical practice, c) looking for validation and permission, d) nursing students' professional self-identity, and e) needing a palliative label.

Influence of professional practice setting norms: "That's just how it is here". The various cultural norms related to serious illness communication in different settings affected if and how participants engaged in serious illness conversations. Many participants described preceptors and/or a practice culture in their clinical setting that actively discouraged having serious illness conversations. Even after receiving SICG training, the lack of valuing of serious illness communication that participants perceived affected whether or not they attempted to engage in serious illness conversations. A participant described their acute medicine placement where they recognized many needs for serious illness communication but was actively discouraged by their preceptor to engage in these. They described a practice culture where serious illness conversations were not a priority. This created a strong influence on the participant who felt conflicted about how to implement this practice:

> I've had CI's [clinical instructors] and mentors say "yes that's important but this is acute medicine but that's just how it is here. I know you're taught differently but it's not feasible here. This is real nursing". It's not that they don't think it's an issue, the lack of conversations, but they don't really do anything about it. (P-04)

Organizational cultural differences related to serious illness communication were clearly articulated by a participant who did a global health placement as a fourth-year nursing student. They described encountering a nursing practice culture that conflicted with the one that they had been taught in school:

> Their culture is very different surrounding talking to patients, health teaching, having these [serious illness] conversations. Nurses don't do any of that. They're basically like,

> "do this, this, this." There's no conversation about what the patient wants, any sort of teaching or anything. (P-07)

Participants also perceived their role and involvement as a nursing student was sometimes overlooked, leaving them unable to engage in serious illness communication within the practice culture of certain settings. A participant reflected on an experience at a Clinical Teaching Unit where they didn't feel welcome or included during serious illness conversations that did occur: "Often I felt like the room was too small. I felt a little bit like an extra body that didn't need to be there, so sometimes I wouldn't necessarily participate" (P-08).

Role modelling and support in clinical practice: "She let me do it". Participants' relationships with their preceptors or mentors appeared to affect if and how they had serious illness conversations with their patients. Some participants described a relationship with their preceptor that was supportive and an environment that valued serious illness communication. A participant described how their preceptor's continuous support positively impacted their confidence engaging in a serious illness conversation at the time, and increased their level of comfort with engaging in serious illness conversations in the future:

> When I asked my preceptor why we hadn't had a serious illness conversation with that woman yet, she indulged me and asked why I thought it was important. It helped me develop a sense of responsibility. She didn't go do it herself. There's some nurses who will do it themselves and not take you. She let me do it. I wouldn't have done it if she hadn't encouraged me in the first place. After she let me do it the first time, I felt more comfortable doing it in the future. (P-06)

Another participant described feeling uncertain in their role as a nursing student. However, having the support of their preceptor allowed them to increase their confidence in having serious illness conversations:

> The fact of having the support of a preceptor definitely makes it better because I feel like as a student, you always second guess yourself just in terms of asking ‘Do I really know what I'm talking about?’ You don't want to make any incorrect recommendation, or blanket statement that isn't really true, so I found having the support of a preceptor was helpful. (P-08)

Role modelling also affected how participants perceived serious illness communication and the role of the nurse in engaging in serious illness conversations. One participant described observing their preceptor in clinical practice, and regarded his approach to serious illness communication as appropriate and effective in the situation:

> [About preceptor] He was really good at asking the right questions at the right time, he knew how to answer the questions, he knew how to respond when they were having lots of emotional things. And he had good body language…he knew how to talk to, when it was the patient and the family members asking questions ... he never got frustrated with patients. (P-07)

Many participants described a tension between what they were told in the SICG training and what they actually saw in practice. The situations they described demonstrated a lack of modelling in clinical practice, and participants did not feel supported to attempt to engage in serious illness conversations. Even after having the SICG training, if participants didn’t see the learned skills validated in their practice setting, they didn’t feel comfortable engaging in serious illness conversations: “…That experience could’ve definitely been a great opportunity for conversation and I feel like no one was really communicating with her or telling her what was going on and what was going to happen…I felt uncomfortable and useless" (P-02). Participants also described feeling that they couldn't engage in serious illness conversations because they had to align their focus with what their preceptor viewed as a priority on the floor:

> My preceptor would always say this thing: "You have to prioritize, prioritize, prioritize". And to me having these conversations should be a priority. But because you're a student, it kind of just shifts to whatever your preceptor thinks is a priority rather than what you think is a priority. (P-04)

Some participants felt that there was a complete lack of modelling of serious illness communication in their clinical practice settings. For instance, a participant stated: "I've never seen that [serious illness conversation] done in practice. And to be honest I can't even think of times when I've just seen conversations about like a patient's wishes" (P-02). Another participant attributed the lack of modelling of serious illness communication in their setting to nurses' discomfort in their skills related to serious illness communication: "I wonder if like nurses themselves aren't comfortable with these [serious illness] conversations. I just haven't heard anything about it. Going to the workshop was the first time I really heard about these types of conversations which is sad" (P-01).

Looking for validation and permission: "I'm not sure if that's my place". Participants described that in order for them to enact the SICG, they needed preceptors who expected serious illness conversations and who would support it in the practice setting. Even after receiving SICG training specific to their position as Level 4 nursing students, participants continued to question their role as nursing students in serious illness communication. Participants' perceived their own limits of knowledge, skill, and judgement contributed to their challenges in initiating serious illness conversations. For instance, a participant described their feelings post-workshop in regard to initiating a serious illness conversation independently. The participant alluded to needing validation and permission to initiate a serious illness conversation and expressed doubt in their abilities and skills related to serious illness communication:

> Not so much, I don't think I'd wanna be the first one to initiate it yet. I'm not that confident in it. And I would also feel like I'm not sure if that's my place as a student. So I think I would be hesitant. But I think I would bring it up. Like I would bring it up to someone later and get their opinion. (P-01)

After receiving SICG training, participants described the concepts of "comfort level" and "scope of practice" hand in hand, which suggested an association between participants' comfort level engaging in serious illness conversations and their perceived scope of practice. Participants reported feeling more comfortable after participating in the SICG training yet they continued to question it in relation to their perceived scope of practice. A participant post-workshop described a situation in a critical care environment where they recognized a need for a serious illness conversation but was hesitant to initiate the conversation. Although they acknowledged that it was appropriate to initiate a serious illness conversation, they didn't feel comfortable doing so and also felt that it was outside of their scope of practice. Furthermore, they felt they needed permission from the patient's family in order to initiate a serious illness conversation, and as a result there were missed opportunities for serious illness conversations:

> And I just felt like something had to be said but I didn't because I definitely felt like it was outside my comfort zone, I also felt it was outside of my scope of practice as a student. In this scenario families weren't even asking me questions." (P-03)

In this situation, the participant did not recognize their role in creating conditions where the family could feel comfortable asking questions related to the serious illness. They also described a need for permission in relation to their role as a nursing student and their scope of practice. Similarly, a participant described their lack of confidence in their knowledge level and related it back to their role as a student:

> As nursing students, we very much feel like students and you constantly question yourself. 'Is it my place to have this conversation?', 'I'm just a student, I don't know anything'. And you think maybe you should leave it to someone more experienced because you're just a student and it's not your role. (P-05)

This quote alludes to a tension between the participant's comfort level engaging in serious illness communication and their perceived scope of practice. Uncertainty regarding scope of practice was also described in relation to the role of the RN**:**

> I don't fully understand what the scope of practice of a Registered Nurse is. Like sometimes when situations arise in the clinical setting I question 'Is this in my scope of practice?' I don't really know, we learned a bit about it but I feel like they were very vague about it. (P-04)

In contrast, a participant described a situation where they felt encouraged and empowered by their preceptor and the nurse to have a serious illness conversation. The participant was encouraged to feel that it was their place and role to engage in the conversation. As a result, the participant described a very successful serious illness conversation with a patient's daughter:

> It was definitely the leeway to have this serious illness conversation. My preceptor was like "that's right and you're going to do it". The nurse on the unit encouraged me to do it

> as well… So I pulled the daughter out of the lunchroom and asked her, “Is it okay if I talk to you about mom for a second?” She was like, “Yeah, of course.” (P-06)

This situation highlights how the participant’s preceptor support was a condition which allowed the serious illness conversation to occur.

Nursing students’ professional self-identity: “I’m a student but I’m going to be an RN”. Although the study interviews took place just weeks before the end of students’ final placement, most participants described their transition from nursing student to RN with a lack of confidence in their skills to have serious illness conversations: “I think just being a new grad, I would still be nervous to implement this” (P-08). However, in regard to the timing of the SICG training, participants felt that they could truly see the relevance of the learning when they could place it within the context of their upcoming transition to the role of an RN: “I’d say probably level 4 would be the best timing. If you got this training in Level 3 you might not be thinking about how you can integrate this into your practice as an RN yet” (P-03). Another participant described that valuing of serious illness communication came with time, and that in their fourth year, they truly became aware of the importance of having serious illness conversations:

> Fourth year is also a really good time to learn about the guide because you’re transitioning into the role of an RN. In second and third year, you’re not necessarily going to have that concept of a nurse yet in some ways whereas in fourth year you realize you’re going to be a nurse in a few months so you realize the importance of it more. (P-02)

One participant described that there were simply more opportunities to practice serious illness conversations during upper level placements, so timing the SICG in fourth year allowed participants to maximize on the opportunities to engage in serious illness conversations:

> I feel like if I was to do it in third year, we also have so many labs in third year for clinical, I feel like it would be more in one ear and out the other. I feel like fourth year you have more opportunity to apply it, and use it, and work with it, so I feel like the beginning, sometime in the first semester of fourth year would probably be the best. (P-08)

Participants described the various "physical" and "basic" skills they had performed during their placement but serious illness communication was not perceived as a "basic" skill by participants. For instance, a participant described their most recent placement on a Seniors Mental Health floor: "A lot of basic care. Many of the patients are immobile and can't really speak anymore so it's just a lot of medication administration and basic hygiene care and feeding and that kind of stuff" (P-01). One participant described that after learning "basic" skills during the first three years of schooling, they felt ready to learn the "finer touch" skills such as serious illness conversations:

> You know you're entering the workforce so you want to learn those finer touch skills. I think in fourth year students are more solidified in their skills. Like hanging an IV is not a problem, I'm not going to freak out if I have to give an injection. So I think it's a good time to focus on those finer skills. (P-04)

Another participant described a situation pre-workshop where they were aware of a need for serious illness conversation but did not address it at the time due to their task-oriented focus:

> In this situation, I didn't explore any of the topics the [SIC] guide mentions, I just kind of went in did my IV's, did basic care, and went out. I was definitely more task-focused at that time. And I had this patient for 2 weeks, and I just did basic skills and care every day. I think now I would just approach it differently than I did then. (P-05)

The participant described feeling uncomfortable initiating a serious illness conversation but also questioned whether it was their role to initiate the conversation: "I guess it was fairly early into the placement and I wasn't fully comfortable in my role yet" (P-05). This tension between comfort level and scope of practice may be because a conversation is less of a tangible skill than participants' perceptions of "basic" skills.

After receiving SICG training, the majority of participants recognized that serious illness communication should be practiced and focused on just as much as the other "basic" skills: "So much of the role of the nurse on this floor was the conversation. We occasionally had to start an IV or give meds or something but so much was the talking piece" (P-05). Participants also described that their transition from nursing student to RN would allow them to better identify with their role and give them a professional identity. One participant described how the realization of their upcoming transition to RN, forced them to practice serious illness communication in the clinical setting and truly grasp the importance of the related skills:

> I'm sure having the title RN, you feel more like a professional and more part of the team. But personally, I've been mentally trying to prepare myself for this transition. I've kind of been telling myself "Yes I'm a student but I'm going to be an RN, and if I were the only RN in this situation I would have to address this, so I need to address this now". And so even if it was scary, I told myself I just had to do it. (P-05)

Needing a palliative label: "there was so much uncertainty". Participants described feelings of uncertainty related to patients' diagnoses which at times led them to avoid engaging in serious illness communication. This practice of needing a palliative label was also validated in clinical practice, as several participants described situations where they observed a physician or nurse avoiding a serious illness conversation due to an uncertain prognosis. A participant post-workshop described a situation where they observed a physician interact with a patient and their family. The patient was seriously ill but did not have a definitive prognosis:

> I feel like it was harder in this situation because there was so much uncertainty. It wasn't like they thought he was going to die. I mean they knew he wasn't in the best condition but it was not like a definitive that he wasn't going to make it. Even though I know we talked in the workshop about how a patient doesn't need to be dying to have this conversation. But I'm thinking that was part of the doctor's thought process, he didn't really view it as a priority to have this conversation. So I feel like no one really has these conversations about goals until it's so late in the serious illness. And even when they have these conversations they don't really dig deep to get a really good understanding. Usually they're just thinking about how to get the patient better but that's not always possible, so what do you do from there. You need to have some guidance as a healthcare provider on what the patient and their family want. In this scenario, I don't think this conversation happened, or at least I wasn't there when it did. (P-04)

Participants also described experiencing a practice culture where patients needed a "palliative" label in order for serious illness conversation to occur. As a result of the lack of serious illness communication, patients didn't necessarily acknowledge their progressive life-limiting illness and shifted their focus to a more curative and rehabilitative mindset that wasn't realistic given their prognosis:

> I heard a nurse [in long term care] say, "I hope they come back from the hospital palliative. I don't want to do that." There's this whole idea that when we're sending patients to the hospital, when they come back, "we're rehabilitating." We're help them getting better now. But really when you have people with COPD and they're dropping

> and dropping and dropping, they're not rehabilitating at some point. Often when patients come back from the hospital as palliative, patients in their minds come back ready to rehabilitate. That's in their brain. They aren't always ready to process that conversation or the nurses feel like they aren't ready to process those conversations. (P-06)

This participant recognized the "big picture" of serious illness when they saw their patients go from the acute hospital setting to their "home" setting in the long-term care home:

> In the acute care setting, everything is so focused on the patient's current state but it's not just an isolated event, it's one part of a bigger picture. And maybe it is easier to see that bigger picture when the patient is in the community and they're in their usual setting. That's when a patient will tell you, "I'm ready to die" but you don't hear that in the acute care setting when the focus is totally different. (P-06)

Part II: Nursing Students' Perceptions of the SICG Workshop

The SICG workshop was provided to fourth year undergraduate nursing students (including those who were interviewed) at McMaster University in a one 3.5 hour workshop. SICG workshop evaluation comments provided by interviewed participants were analyzed and categorized into three major themes: 1) applicability of SICG training to practice, 2) strengths of SICG training, and 3) limited opportunities to develop competence. Each theme was composed of several components. See Table 4 for a list of themes related to SICG training.

Table 4. Nursing Students' Perceptions of the SICG Workshop

Themes	Components
1. Applicability of SICG training to practice	a) Linked learning experiences intentionally to clinical practice: "*It's very connected to some of the things I had to do in clinical"* b) Provided a structured approach: *"It's nice to just know the order of things"*

	c) Facilitated establishing opportunities for serious illness conversations: *"A way to delve deeper"* *d)* Using it in part: *"taking bits and pieces"* e) Adapting it to different settings*: "it* [SICG] *could apply anywhere"*
2. Strengths of SICG training	a) Created realistic clinical scenarios by using standardized patients: *"Here's your situation, go ahead and try"* b) Provided easy access to learned materials: "*I have quick access to the guide in my pocket"* c) Lacked a formal grading measure: *"there was no opportunity to fail"*
3. Limited opportunities to develop competence	a) Time constraint: *"Time kind of just escapes you"* *b)* Lack of opportunities to practice: *"I haven't really had a chance to practice them too much"* c) Unit culture*: "That's not something we have to do"*

Theme One: Applicability of SICG training to practice

Participants were asked how the SICG workshop could be integrated into the undergraduate nursing curriculum. The SICG workshop was perceived to impact the way that study participants practiced in their professional practice placements. Additionally, participants discussed the perceived usefulness of SICG in relation to their intentions to apply the training in future clinical practice. The SICG workshop was perceived to have a) linked learning experiences intentionally to clinical practice, b) provided a structured approach, c) facilitated establishing opportunities for SIC, d) using it in part, and e) adapting it to different settings.

Linked learning experiences intentionally to clinical practice: "It's very connected to some of the things I had to do in clinical". Participants emphasized that they needed to see the relevance of learned material related to serious illness communication in the context of actual practice experiences. Participants found that it was easier to understand and learn about serious illness communication when they could see the direct importance in their practice setting. The majority of participants felt that the SICG made it easy to link the learned concepts to clinical practice. For instance, a participant stated: “I was doing this workshop and I thought you can grasp this guide and information, it’s very relevant and it’s very connected to some of the things I had to do in clinical” (P-06). In first year with no exposure to the clinical setting, participants felt that they would value these conversations less than they currently did. A participant stated: “It might be too early to do it in first year because you don’t even have clinical placements” (P-02). Participants also described a need for exposure to a population that makes the SICG relevant to the learner. One participant recognized the medical issues that lead to patient contexts in which serious illness conversations are needed when they stated: “I think one thing that made this workshop real to me is and to see the intrinsic value of it was being exposed to a patient population characterized by chronic co-morbidity and serious illnesses like chronic heart failure, Alzheimer’s, diabetes, CHF” (P-03).

Provided a structured approach: “It’s nice to just know the order of things”. Participants described the SICG order and structure as beneficial for them. The specific “patient-tested language” and general framework allowed participants to perceive they could navigate serious illness conversations more confidently and effectively. One participant stated: “It’s kinda nice to just know the order to do things and if you were to have a whole entire conversation to know where to go with it. I think the guide flows very well” (P-02). Participants also found that the “patient-tested language” in the SICG helped frame their conversations, and being able to have the questions with them increased their confidence when engaging in serious illness conversations. One participant stated:

> I loved how it had the questions that you can specifically ask patients. All the other [guides] were like, "you say something about this general topic," but didn't give you actual questions that you could say to the patient, which is what I liked most about it, was that it had those questions that you could directly read off. (P-07)

Facilitated establishing opportunities for serious illness conversations: "A way to delve deeper". Participants perceived that the SICG facilitated identifying and establishing opportunities to engage in serious illness conversations. Participants described situations where they recognized cues and opportunities for serious illness conversations in clinical practice. One participant stated: "I got a better sense of how to identify when a patient was ready to talk about things, or wanted to share something" (P-08). The SICG was also perceived by participants as helping to set up an environment that made the patient feel more comfortable and receptive to engaging in a serious illness conversation:

> When you have someone who's nervous to talk or reluctant to share information about themselves, I want them to talk more and feel comfortable but I used to not know what to say to help them with that, so the guide gave me key things to focus on. It gave me a way to delve deeper into their story. (P-05)

Another participant described how using SICG allowed them to overcome their hesitation in regard to initiating a serious illness conversation and allowed them to set up the conversation in a way that made the patient's family receptive to engaging in the conversation:

> I think the biggest thing about the guide was that it teaches you how to approach the conversation. It makes an open environment for that conversation. I feel like there's times where nurses are scared to talk to family because they don't want to offend family.

> Family aren't ready to talk to nurses. They're not ready to receive that information and the workshop helps overcome that barrier. (P-06)

One participant described how the biggest thing they took away from the workshop was one phrase in the SICG's "patient-tested language". The phrase allowed them to feel comfortable initiating a serious illness conversation and created an opportunity to engage in deeper dialogue. The participant stated: "Opening up that conversation using that phrase 'We hope this isn't happening but I'm worried that…' just makes it so much easier to touch on all those points cause it really sets it up for you" (P-04). Similarly, a participant described the SICG's open-ended questions to be a facilitator:

> I really like parts of the guide because it's very open-ended. One question that I really like to ask patients and families is: 'tell me about your understanding of…' I also love asking about expectations because that reveals a lot. (P-03)

Using it in part: "taking bits and pieces". The perceived usefulness of SICG training was explored in relation to participants' intentions to apply the training in future clinical practice. The majority of participants felt that using parts of the SICG was the most practical and effective way to integrate it into their practice. One participant stated:

> I can't see myself using the whole thing but in certain situations you can just grab a little part and it can help you navigate a difficult conversation better and hopefully have a conversation that in the long term is more beneficial for the patient. (P-02)

Another participant also used the word "navigate" to describe how using parts of the guide was useful in a specific serious illness conversation: "I didn't really use the guide word for word but I was thinking about it and if there were spots I could pull to help me navigate the situation better" (P-01).

Participants felt that even using certain phrases from the SICG's "patient-tested language" helped them initiate and engage in a serious illness conversation effectively. One participant described how a single phrase from the SICG allowed them to convey the intended message to a patient's family:

> I don't think I necessarily used the guide in this conversation but I did take bits and pieces from the guide that were really helpful. Like I remember saying "We hope that he didn't aspirate, but I'm worried that…" and it was nice to have a sentence that I knew could properly say what I wanted to say to the family. (P-04)

The idea of using parts of the SICG when engaging in serious illness talk was referenced by the majority of participants and was described as a useful tool.

Adapting it to different settings: "it [SICG] could apply anywhere". Participants described using the SICG by taking the learned concepts and adapting the guide to the needs of different settings and practice contexts. As study participants were placed in a variety of settings for their final professional practice placements, the interviews revealed various ways in which participants were already adapting the SICG to different settings and ways in which participants felt they could adapt the guide to future settings. One participant described using the SICG with a mental health population to better frame conversations about the future:

> I had some patients who it was like their first time ever encountering any sort of psychiatric care and they're going through all different emotional trauma and childhood abuse and I'm like the first person they're telling these things to and I feel like this [SICG] helped me frame those conversations better. (P-05)

Another participant described the ways in which they foresee using the SICG on a pediatric oncology floor. They predict that they will likely use parts of the SICG to frame conversations with both families and children:

> I want to go into ped-oncology, so I definitely think that that's something that will be talked about. It'll be good to have the knowledge from the tool itself, even just the questions and how they're phrased to ask those questions. In ped-oncology, it's more asking the parents about that stuff because the kids are often fairly young. But when you've got the older teenagers, what do they see as their future, what things do they want or not want. (P-07)

Overall, participants felt that the guide was applicable in a variety of settings and easily adaptable for use in various situations. One participants stated: "I see how this workshop could work on any unit that I'm working on and that it could apply anywhere. The whole concept is around Plan B and everyone wants a Plan B" (P-06).

Theme Two: Strengths of SICG training

The participants perceived that the SICG training had many strengths as it: a) created real clinical scenarios by using standardized patients, b) provided easy access to learning materials, and c) lacked a formal grading measure.

Created realistic clinical scenarios by using standardized patients: "Here's your situation, go ahead and try". The most frequently cited strength of the SICG training was the use of standardized patients. Participants felt that the standardized patients allowed them to apply the learned concepts in a practical way. A participant stated: "I really liked having the standardized patients. It's one thing to read about something and think about how you would do it but then when you actually have to do it, it's completely different so I really liked that" (P-01).

Participants also felt that the clinical scenarios involving standardized patients gave them an opportunity to test out their skills before taking them to their professional practice placements. Speaking of the standardized patient experience, a participant stated: “That was hands down the best learning experience that I could have got. Because it's just like being thrown into it and being like, ‘here's your situation, go ahead and try’” (P-08). The standardized patients also provided a commentary on participants’ performance in a mock serious illness conversation scenario using the SICG. This commentary was positively regarded by participants: “The standardized patients provided us with valuable feedback on how we had participated in the serious illness conversations” (P-06).

Provided easy access to learning materials: “I have quick access to the guide in my pocket”. Every participant who attended the SICG training received a pocket version of the guide and a binder they could keep post-workshop that included relevant materials and resources. Participants perceived that the easy access to the SICG training materials helped them incorporate the concepts into their practice. Furthermore, participants appreciated that the workshop leaders supported having the SICG in hand when engaging in a serious illness conversation with a patient. One participant stated:

> I liked how they gave us a pocket version of it that you can carry around, so if I’m ever in a situation talking to a patient or family, just knowing that I have quick access to the guide in my pocket with all the prompts I need is really handy. And I liked how they emphasized the point that you can absolutely have a conversation and have the guide in your hand while you do so and that doesn’t make you incompetent. (P-04)

Participants who attempted to use the SICG with patients also found that patients had no issues with them using the physical copy of the guide when having a conversation. One participant stated:

> What I liked most about it, was that it had those questions that you could directly read off. And patients are often fine with you bringing in a piece of paper with you and reading off of it. They don't care. (P-08)

Lacked a formal grading measure: “there was no opportunity to fail. The lack of formal grading measures associated with the SICG training was perceived by participants as a strength of the training: “Knowing that it wasn't a testing measure, so there was no opportunity to fail, it was just like, try it, see how it goes. If it goes well, great, if it doesn't, it doesn't” (P-08). Participants felt that the SICG workshop’s lack of grading allowed them to take their time and truly immerse themselves in the concepts being taught. They were more open to asking questions and felt that the format made everyone feel encouraged to participate in the standardized patient situations: “We weren’t just being spoken to and having information thrown at us. We actually had time to practice it, and I felt comfortable asking questions because I knew there was no grading involved” (P-05).

Theme Three: Limited opportunities to develop competence

Even with SICG training, participants identified several barriers to uptake in the clinical setting. The barriers to using the SICG training in their professional practice settings including: a) time constraints, b) lack of opportunities to practice, and c) unit culture.

Time constraint: “Time kind of just escapes you”. Many participants recognized a lack of time as a barrier in being able to apply SICG training. One participant described that limited time was due to increased workload related to the patient assignments on an acute medicine unit:

> I feel like there’s so much work that I have to do, so many task to complete in a day that the time kind of just escapes you. So even when I know in the back of my head that we need to have this conversation, I just physically couldn’t have that conversation and take the time to sit down with anyone. The holistic approach nursing care that you’re taught to have you can’t have because there’s just all these tasks to do and if you don’t complete them, you’re liable. And because there’s so many tasks that you have to complete, even if you push them aside they still have to get done and I would just have to stay later in the shift. (P-04)

Another participant described challenges with time constraints in a clinic setting where clients have appointments with a set time limit and limited flexibility in the schedule:

> The clinic setting is challenging because patients have prescribed visit time with you. So it's like, where do you forgo other patients' time with you versus that patient’s time? That sounds selfish, but just in terms of you can't give patients three hours when they have a half hour scheduled. (P-08)

Lack of opportunities to practice: “I haven’t really had a chance to practice them too much”. Participants identified a lack of opportunities to practice the SICG depending on their clinical setting and the level of support available to them in that setting. One participant described how their knowledge of the material decreased as time went on as they didn’t have as many opportunities to use the SICG in the clinic setting they were placed in: “I find with information like this, workshops and whatnot, you feel very saturated with the knowledge at first, and then if you don't really work with it in this setting, it kind of dissipates” (P-08). Another participant recognized that although the guide provided them with the tools they needed to engage in a serious illness conversation, their discomfort due to lack of experience prevented them from actually practicing the SICG in the clinical setting: “The guide definitely helps give an idea of how to structure these conversations but I still find it uncomfortable to do because I haven’t really had a chance to practice them too much” (P-01).

Unit culture: “That’s not something we have to do”. The unit culture in participants’ various placements was perceived as a barrier to engaging in serious illness communication. For instance, a participant described a lack of support from his preceptor and a unit culture that did not support the practice of serious illness communication:

> There was a lot of patients on that floor that I could’ve had the conversation with and it just didn’t happen because I would tell my nurse about it and she’d say “Oh that’s not something we have to do, the doctor has to do that.” (P-04)

If the unit culture did not support serious illness communication, participants described feeling uncomfortable engaging in serious illness conversations. Furthermore, a lack of role modelling of these skills by their preceptors and other nurses on the unit left students unsure of their role in initiating serious illness conversations.

CHAPTER 6: DISCUSSION

Overview

This chapter provides a discussion of the study's main findings related to undergraduate nursing students' experiences of engaging in serious illness communication and their perceptions and recommendations regarding SICG training. New contributions that this study adds are highlighted and described considering key findings in the literature. The main findings of this study are a) despite training and easy to use tools, serious illness communication is very difficult for students to apply in practice, b) nursing students experience moral distress in practice because they lack the confidence and skills to engage in serious illness conversations, and c) SICG training needs to be provided in a way that it can be adapted to different patients in a variety of settings.

This is the first known study to evaluate use of the SICG in undergraduate nursing students. The majority of participants strongly supported including the SICG workshop in formal undergraduate nursing education. The majority of current literature related to the use of SICG is related to implementation of the entire Serious Illness Care Program with healthcare professionals in various settings (Bernacki et al., 2019; Lakin et al., 2017; Lamas et al., 2017a; Lamas et al., 2017b; Paladino et al., 2019).

Key Findings in Relation to the Literature

Despite training and easy to use tools, serious illness communication is still very difficult for students to apply in practice. An important finding of this study is that despite receiving training, students perceived serious illness communication challenging to enact. These findings support previous research that suggests nursing students find serious illness communication to be a challenging skill to put into practice (Gallagher et al., 2014; Gillan et al., 2014; Gillett et al., 2016). Further, the current study found that these challenges persisted even after students received formal serious illness communication training. Study participants recognized that serious illness communication was an area of practice they wished to improve on and had all voluntarily participated in the workshop. After attending the SICG workshop, participants had placements in a variety of settings, which provided them with different opportunities to engage (or not) in serious illness communication within different patient contexts and to attempt to develop meaningful relationships with patients and their families. Although participants rated their confidence highly in several components of the SICG during the pre-interview questionnaire, they acknowledged still feeling hesitant to engage in serious illness conversations in their various professional practice environments. In a previous study conducted by Tam et al. (2019), confidence has been measured shortly after students received communication training and found that there was a significant increase in students' perceived knowledge and self-efficacy directly after participating in the SICG workshop. In the current study, the majority of students were asked about their experiences implementing serious illness communication skills up to three months post SICG education. While it would be hoped that in the time since training, participants would have had time and opportunity to develop confidence through application of the SICG techniques, only nine critical incidents were cited in which three of the eight students used the SICG after the training. Had I surveyed students before and after the SICG workshop, differences in the pre- and post- training could have been assessed. For those who did not have opportunities to practice the SICG or its components, the duration of time elapsed since participating in the training likely influenced participants' perceptions about their skills engaging in serious illness communication. These findings reveal a need to further help nursing students find ways to adopt the SICG in their practice with seriously ill patients and families and to support them in developing and sustaining these skills in their future practice.

In the current study, nursing students felt uncomfortable applying serious illness conversations in the clinical setting due to their lack of experience engaging in them. These findings may be explained by Bandura's (1984) self-efficacy theory which describes how earlier attempts at completing a task (or not attempting) influences how an individual perceives their ability. Individuals' self-efficacy is also influenced by what they observe or hear from others who have completed the task (Bandura, 1984). Thus, in order to help nursing students increase their self-efficacy in engaging in serious illness conversations, it is important for their preceptors and clinical instructors to encourage and support them by identifying opportunities, modelling and mentoring and facilitating reflection related to their concerns, challenges and experiences. Furthermore, self-efficacy theory indicates that students may need more than just one day of SICG training. By providing students with multiple experiences that build on one another over time, they would have the opportunity to build greater comfort and confidence in serious illness communication (Isaacson et al., 2019).

Participants had the lowest confidence ratings for the SICG component of "allowing for silence." A lack of comfort with silence also frequently emerged in students' narratives during the interviews. These findings are consistent with previous literature that indicates that using silence as a way of being present with patients and their families can be difficult for students (Emory et al., 2018; Sanford et al., 2018). Although the SICG training reinforced using silence as a therapeutic tool in serious illness conversations, participants described heightened feelings of uncertainty and discomfort during an emotionally charged situation when attempting to allow for silence. Despite their perceived difficulties in implementing this skill into their practice of serious illness communication, students acknowledged the importance of intentional silence in many of the situations they described. This finding indicates a need for communication training to continue emphasizing the role of silence as a therapeutic intervention for patients and their families. Student participation in specific case scenarios or role play activities that highlight using silence and active listening may encourage students to continue attempting to implement this in their practice (Emory et al., 2018)

Participants described a variety of perceived barriers that prevented them from engaging in relational practice through serious illness conversations. At the forefront of these barriers was the practice culture that students encountered in their professional practice placements that often did not support the application of learned serious illness communication skills. Participants' descriptions of their experiences demonstrate that SICG training must be reinforced in professional practice settings. Findings suggest that undergraduate nursing education that aims to include SICG, needs to address this theory-to-practice gap so that serious illness communication is better modelled in clinical practice and as a result valued by students. To address this skill gap, serious illness communication training should occur in workshops but must also be supplemented with hands-on student participation in practical learning (Shoghi et al., 2019; Van Dalen, 2013). A study by Esmaeili et al. (2014) found that students expected both theory and practice to be incorporated during their clinical placements. Reminders from clinical instructors about how to use the skills and knowledge they learned in the classroom led to effective learning (Esmaeili 2014). In a qualitative study conducted by Gillet et al. (2014), students described that getting a theoretical basis for serious illness communication could only prepare them to some extent for the reality of engaging in these conversations in clinical practice. In the current study, participants felt that the use of standardized patients during the SICG training allowed them to apply the learned concepts in a practical way more than just receiving formal theoretical training on the subject.

Nursing students are currently experiencing moral distress in practice because they don’t have the skills to engage in serious illness conversations. The second key finding of this study is that moral distress is experienced by nursing students in the context of serious illness communication. Previous studies have found that moral distress experienced by nursing students in various contexts has potential negative consequences on students’ wellbeing (Bordignon et al., 2019; Hazelwood et al., 2019; Krautscheid et al., 2017; Sasso et al., 2016). Participants in the current study described feeling moral distress when they did not engage in serious illness conversations during situations that they felt it was needed. Their inaction was linked to an actual or perceived lack in knowledge, confidence and/or skills to have such a conversation. The morally distressing situations that participants described had sometimes occurred in previous terms, yet they were able to recount the incidents in rich detail; indicating that these experiences still had meaning to them. Allchin (2006) conducted a hermeneutic study that found that students continued to think about their experiences of caring for a dying patient long after the clinical day had ended. Students in their study felt that caring for dying patients and their families was one of the most distressing tasks for which a nurse was responsible (Allchin, 2006).

Students in the current study identified a lack of opportunity to formally debrief after serious illness talk experiences and this forced them to seek their own methods of coping with these experiences. Similarly, participants in a study conducted by Gillett et al. (2014) reported students having to make sense of situations on their own and identified a lack of formal opportunities to discuss these experiences in education programs. Feelings of moral distress can be reduced when students participate in debriefing and discussion, and seek peer support

(Hazelwood et al., 2019). Limited support and opportunities for sharing experiences through discussion with their mentors or peers leaves students to make sense of ethically challenging serious illness situations for themselves (Bengtsson & Ohlsson, 2010). Krautscheid et al. (2017) found that nursing students who experienced moral distress as nursing students continued to experience compassion fatigue post-graduation. This was associated with increased turnover and burnout in new graduate nurses (Krautscheid et al., 2017; Rudman & Gustavsson, 2011). Thus, it is possible that incorporating and supporting SICG training and practice may have positive implications on nursing students' future mental health.

Although previous studies have examined the experience of moral distress amongst nursing students, the current study's findings linked students experience of moral distress with their capacity to engage in serious illness communication. After receiving SICG training, participants felt that their increased capacity to attempt to engage in serious illness conversations served to somewhat lessen their distress. This indicates that the SICG not only may have outcomes for the patient and family who will have an opportunity to discuss their goals and wishes, but also may have a positive outcome for nursing students.

SICG training needs to be provided in a way that it can be adapted to different patients in a variety of settings. The third key finding of this study is that nursing students frequently tailored the SICG to a particular patient and care situation. Study participants described ways that they used parts of the SICG (referred to herein as "serious illness talk") while caring for patients experiencing serious illness and found it to be the most practical and effective way to integrate the SICG into their practice. The "patient-tested language" in the SICG was cited by participants as increasing their confidence in initiating serious illness conversations. These findings are consistent with a study conducted by Tam et al. (2019) that evaluated medical students' knowledge, comfort and confidence in holding serious illness conversations after receiving a 2.5 hour SICG workshop. In their study, participants reported gaining a framework and appropriate phrasing to engage in serious illness conversations (Tam et al., 2019). Participants felt that the SICG gave them a framework and guide on what to say, even when they were placed into situations with which they were completely unfamiliar.

A recent study by McGlinchey et al. (2019) explored the perspectives of key stakeholders and patients about the Serious Illness Care Program to consider whether adaptations were required for use in the UK. The results of the study suggested that clinicians should be able to adapt the language and format of the SICG to better account for what is important to individual patients during a serious illness conversation. Some of the language in the guide was considered too formal by participants and too closely resembling an interview. The SICG was described as working best when the guide's specific prompts were used as part of a natural conversation (McGlinchey et al., 2019). These findings are consistent with the current study where students described feeling more comfortable using parts of the guide and adapting the conversation to fit in during informal moments of care.

Limitations

There were several limitations of this study. As the pool of eligible participants only included fourth year undergraduate nursing students who had participated in SICG training, a small minority of the undergraduate nursing class, the findings only reflect the perceptions and experiences of a small group of students in the nursing program. Furthermore, the sample of participants was taken exclusively from one Ontario university, which may make the applicability of findings to the broader context of Canadian undergraduate nursing not possible. However, as generalizability in a broad context is not the purpose of qualitative inquiry, the study will still serve its purpose of providing rich description of experience related to a specific population (Patton, 2015). Additionally, as both the SICG workshop and the study required voluntary participation of students, it may be that students who chose to participate were more interested and engaged in the topic of serious illness communication. Finally, the study did not include pre- and post-workshop scores for the participant questionnaire confidence levels in using the SICG, which limited the conclusions that could be drawn regarding the usefulness of SICG training for undergraduate nursing students.

CHAPTER 7: IMPLICATIONS AND RECOMMENDATIONS

This final chapter summarizes the implications and recommendations of the study findings in the context of nursing education, professional practice settings, future research and policy.

Implications and Recommendations for Nursing Education

One of the most important implications of this study is that undergraduate nursing students could benefit from more educational support in engaging in serious illness communication in various clinical settings. Areas of support identified include nursing curriculum development and nursing educators. The implications and recommendations related to these areas will be discussed in this next section. See Table 5 for specific intervention strategies for integrating serious illness communication concepts and skills into nursing curricula.

Nursing Curriculum. Study findings support the need for formalized education regarding serious illness communication in undergraduate nursing programs. Making serious illness communication skills a formal learning outcome would motivate nursing students to develop their skills in this area and contribute to recognizing such skills are both important to practice and part of a nurse’s role. Incorporating structured serious illness communication training into nursing education would increase nursing students’ confidence and skills with a goal of improving patient outcomes (Bernacki, et al., 2014; Lakin et al., 2016; You et al., 2014). The SICG and workshop may be helpful in providing such structure. The SICG workshop is informed by adult learning principles and utilizes various learner-centered educational strategies to optimize participants’ understanding and retention (Tam et al., 2019). For optimal learning, students also require multiple opportunities to practice serious illness communication skills as these build on one another over time (Isaacson et al., 2019). Study findings clearly indicate there is a need to increase the number and quality of learning opportunities regarding students' interactions with families experiencing the serious illness of a loved one and its implications. Opportunities for serious illness communication praxis with families could provide much needed confidence, knowledge and skills for families who face uncertainty and loss.

Serious illness communication needs to be incorporated into both theory and practice throughout undergraduate nursing curricula. Students in different levels of their undergraduate nursing education have different needs for serious illness communication knowledge and skills (Wallace et al.,2009). In the current study, participants in their final term of a four-year BScN, felt that they needed more exposure to the concepts of serious illness communication early on in their program and then actual practice with these concepts further in their undergraduate studies. Opportunities for students to develop their serious illness communication skills should be structured to promote self-efficacy; formal grading measures were seen to hinder this process while one- to- one rehearsal with standardized patients helped students feel comfortable to take "risks" in using the SICG.

Nurse Educators. Throughout their undergraduate nursing education, students will have had a variety of clinical placements in which they may have been exposed to, engaged in, or recognized the need for serious illness communication. Nurse educators must attempt to incorporate serious illness communication content in a meaningful way so that students have the opportunity to engage in self-reflective practice and connect the learned concepts to a range of patient situations (Henoch et al., 2017; Josephsen & Martz, 2014). In particular, reflections on and modelling of the therapeutic use of silence with patients and families offers a way for students to increase their comfort with silence.

Preceptors and clinical instructors in laboratory and professional practice placements play a significant role in nursing education. Students need an environment where they aren't being graded, they can practice with "real" patients, they have support and role models, and time to talk about moral and ethical dilemmas (Gallagher et al., 2014; Josephsen & Martz, 2014). The way that students see their preceptors and clinical instructors engage with seriously ill patients can have an emotional influence on students (Sanford et al., 2011; Wallace et al., 2009). Yet, many practicing nurses are uncomfortable engaging in serious illness communication and consider it to be a particularly challenging area of practice (Croxon et al., 2018). This practice gap needs to be addressed as it may negatively affect students who look towards their preceptors and clinical instructors for role modelling related to serious illness communication. Manokore et al. (2019) found that different clinical instructors have different expectations and scaffolding supports. Undergraduate nursing programs may benefit from creating skills workshops for clinical instructors that focus on facilitating learning and scaffolding supports that would help students better engage in the learning material (Manokore et al., 2019). Training nursing faculty, instructors and preceptors to be SICG workshop trainers or at the very least, encouraging their attendance at a SICG workshop, may offer a way to boost the capacity for promoting student application of serious illness talk in professional practice settings. In this way, students would also be encouraged to value communication as a vital part of care and not as an added nicety of practice.

Table 5: Intervention Strategies for Integrating Serious Illness Communication Concepts & Skills into Nursing Curricula

Intervention Strategies
1. Introduce relevant concepts and skills embedded in serious illness communication early in the BScN program. Strategically level and link the knowledge and skills with professional practice experiences.
2. Increase the focus on knowledge and skill development for communicating with families of persons living with serious illness.
3. Develop learning outcomes with regards to serious illness communication in the context of inter-professional practice: Include ACP, Goals of Care and Decision-making (differentiate from DNR decisions).
4. Embed opportunities for guided self-reflection about serious illness communication within professional practice to develop and support emotional readiness and resilience.
5. Engage students, patients, and clinical partners in the design, implementation, and evaluation of serious illness communication education strategies and simulations that are meaningful for students.
6. Develop the capacity of nursing faculty and clinical instructors to have serious illness communication knowledge, competence and confidence using the SICG. Implement a train-the-trainer approach that focuses on supporting clinical instructors and faculty members in learning about the Serious Illness Care Program.
7. Create learning opportunities in simulation for students to apply the SICG and the Serious Illness Care Program Reference Guide for Interprofessional Clinicians.
8. In collaboration with clinical partners, develop and strengthen organizational commitment and support for expanding opportunities for students to engage in serious illness communication experiences in clinical settings.
9. Provide guidance to and support for clinical instructors related to formal debriefing strategies to implement with students regarding serious illness conversations and their implications.

Implications and Recommendations for Professional Practice Settings

A fundamental finding from the research is the influence of organizational and unit specific culture on students' experiences engaging in serious illness communication. Henderson et al. (2011) suggested a general framework that can be used to develop a clinical learning culture in hospitals and other healthcare facilities; this has relevance for creating a culture where serious illness conversations and talk is valued and supported. They propose that the concepts of leadership, management and partnership all play a role in creating and sustaining conducive learning environments for nursing students. To promote staff nurses' engagement in undergraduate education on a particular unit, promotion of educational initiatives to help those nurses develop the necessary skills to guide and facilitate the learning of nursing students may be helpful. Furthermore, cultivating open dialogue to develop the student learning culture should occur between clinical placements and the nursing education organizations so that nursing staff and students can maximize the learning opportunities available to them (Henderson et al., 2011). It is important if serious illness communication is to develop within a care system, nursing programs must find ways to engage their clinical partners in making nurses' serious illness conversations an expected practice. This would create conditions for students to value and engage in these conversations with patients and their families.

Originally, the SICG was meant to be a tool used as a roadmap for a conversation that could be revisited over time. However, the study's findings suggest we need to help students explore the opportunities for serious illness talk to be embedded in their varied professional practice contexts, and when possible to use the SICG as a whole and finally, learn to effectively use the SICG within a team. In this study, participants described that in certain professional practice settings, they had adapted the SICG for various reasons such as to suit the developmental stage of a child and environmental barriers in the clinical setting.

Implications and Recommendations for Research

From a research perspective, there are many implications for additional studies regarding undergraduate nursing students engaging in serious illness communication using the SICG.

Taking into consideration the small scale of the study, further research is needed to confirm the transferability of these findings in other nursing schools, to determine the optimal sequencing and timing of this SICG training during the undergraduate nursing curriculum, and to determine the ideal balance between using the SICG as a standardized tool for serious illness conversations and enabling adaptation of the approach such as serious illness talk. The inclusion of focus groups in future research may stimulate more in-depth discussions and generate further information and recommendations surrounding nursing students' experiences engaging in serious illness conversations in their professional practice placements. An alternative approach would be a longitudinal study which follows a group of nursing students through the four years of their nursing program and incorporates a range of instruments of enquiry. This approach would help provide further evidence on how to sustain purposeful use of the SICG in nursing students' practice.

While the cost of using standardized patients increased workshop costs, this arguably created more realistic situations than peer role playing. Given this, research comparing the use of standardized patients and role playing with peers would be useful in future to more fully support approaches to SICG training integration at different levels of nursing education.

Implications and Recommendations for Policy

The CHPCA released a document entitled "The Way Forward National Framework: A Roadmap for an Integrated Palliative Approach to Care". The document provides a national framework outlining a roadmap for integration of palliative care into all settings. Although it acknowledges the need for improved, high-quality, accessible palliative care in Canada and stresses the importance of providing nurses with ongoing education and support in palliative care, there is no mention of the role of undergraduate nursing institutions in facilitating this education (CHPCA, 2015). This reflects the need for alignment of policy and not continued siloing of various levels of nursing education within healthcare sectors. A national strategy should include a policy that requires nursing schools to implement mandatory palliative care education with a specific focus on serious illness communication. Organizations should also ensure that nurses meet entry-to-practice palliative care competencies in care settings that provide care to individuals experiencing serious illness, support nurses to develop them, and include these competencies within hospital policies.

Conclusion

Overall this study provided an in-depth exploration of undergraduate nursing students experiences of engaging in serious illness communication using the SICG in their professional practice placements. This study revealed that undergraduate nursing students find serious illness communication to be challenging to enact with their patients and families even when they have the appropriate training and tools. Furthermore, many participants described experiencing feelings of moral distress that they did not have the chance to explore or debrief with their mentors or peers. These unresolved feelings could lead to compassion fatigue and burnout. The practice culture of students' clinical placements influenced how comfortable and confident students felt practicing serious illness communication.

This is the first known study to explore application of the SICG training in undergraduate nursing students. Study findings revealed undergraduate nursing students' perceptions of the SICG training. Participants found that adapting the SICG to different patients and clinical contexts was a useful way to incorporate the SICG into their practice. They found that the SICG training created realistic clinical scenarios by using standardized patients and provided easy access to learned materials. Participants also identified several factors that limited their use of the

SICG in their practice (e.g. time constraints, lack of opportunities to practice, and professional practice unit culture). The majority of participants strongly supported the strategic inclusion of the SICG workshop and its components in formal undergraduate nursing education. The integration and uptake of the SICG in nursing education has the potential to positively shape the experience of patients and their families living through serious illness and to increase the capacity of nursing students to have a more satisfying professional practice.

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APPENDICES

Appendix A

Glossary of Terms

Advance care planning: The aim of advance care planning is to give individuals the opportunity to discuss their values and wishes so that these may be known for future healthcare decision making. Advance care planning includes clarifying a patient's understanding of their illness and treatment options; and understanding a patient's values, beliefs, and wishes (HPCO, 2016 & MacKenzie et al., 2018).

Critical incident: An incident is "any observable human activity that is sufficiently complete in itself to permit inferences and predictions to be made about the person performing the act" (Flanagan, 1954). The term 'critical' is used to describe an incident with a clear intent and definite outcomes (Flanagan, 1954). For this study, a critical incident was defined as any memorable serious illness conversation that a nursing student had with a patient and/or family member.

Critical incident technique (CIT): A method of data collection that seeks to collect specific incidents regarding a phenomenon of interest, and has been found to be particularly useful in exploring dimensions of nurse-patient interactions (Flanagan, 1954; Kemppainen, 2000).

Goals of care: Describes an individual's goals for their care and should include acceptable interventions of the disease and/or symptom management. In some cases, goals of care can include limits on the interventions that individuals want, such as "do not resuscitate" orders (CHPCA, 2015).

Palliative approach to care: Care that focuses on meeting an individual's and family's needs holistically, at every stage of a life-limiting progressive illness. A palliative approach to care places particular focus on "open and sensitive communication about the person's prognosis and illness, advance care planning, psychosocial and spiritual support and pain/symptom management" **(**CHPCA, 2015).

Serious illness conversation: A discussion or series of discussions between a clinician and patient that starts early in the course of serious illness and focuses on the patient's values, goals, and care preferences. A serious illness conversation should provide a foundation for making decisions in the future, and should be reviewed over time. (Ariadne Labs, 2020)

Appendix B

Summary and Evaluation of Studies Included in the Literature Review

Serious Illness Communication

Study	Study Authors	Date	Research Question(s) and/or Aim(s)	Methodology	Setting and Sample	Main Findings of Relevance for Present Study	Critique
Communication About Serious Illness Care Goals A Review and Synthesis of Best Practices	Bernacki & Block	2014	The review has two aims: 1) review the evidence and describes best practices in conversations about serious illness care goals (2) offer practical advice for clinicians and health care systems about developing a systematic approach to quality and timing of serious illness communication.	Narrative review article. Both observational and intervention studies were included.	**Setting**: Primarily ambulatory setting. **Sample**: The studies selected reported on a variety of serious illnesses including cancer, congestive heart failure, chronic obstructive pulmonary disease, and chronic kidney disease and/or end-stage renal disease.	The review found that there are patient, physician, and system factors that contribute to ineffective serious illness communication. When serious illness communication is initiated early, there are beneficial outcomes for patients such as better quality of life, less aggressive treatments near death, and earlier referrals to hospice. Clinician education was	**Strengths:** The literature review included studies evaluating communication practices with a variety of serious illnesses, increasing the generalizability of findings. **Limitations:** The majority of consistent results were found in medium to low studies conducted in

						identified as an essential component in improving serious illness communication.	an oncology setting, raising questions about their generalizability to other settings. The tool used to evaluate the quality of studies was not identified.
A Systematic Review of Communication Quality Improvement Interventions for Patients with Advanced and Serious Illness	Fawole, Dy, Wilson, Lau, Martinez, Apostol, Vollenweider, Bass, Aslakson	2012	The aim of the review explored the effectiveness of communication-related quality improvement interventions for patients with advanced and serious illness	Systematic review. The review included 20 prospective, controlled quality improvement studies.	**Sample**: The studies had sample sizes that ranged from 63 to 2,891 patients. One of the studies reported on a pediatric population, the other studies focused on adult populations between 40 to 87 years of age. **Setting**: Thirteen of the studies were conducted in an intensive care unit, two studies	Most of the studies evaluated healthcare utilization outcomes, such as length of hospital stay and use of aggressive treatments, and found statistically significant effects of the education interventions. Some studies evaluated outcomes of satisfaction, quality of life, and symptom control, and found predominantly	**Strengths**: Comprehensive literature search was performed. Four databases were searched. Study selection was clearly outline. **Limitations**: Study heterogeneity did not allow for quantitative synthesis of the literature.

					were conducted in an ambulatory care setting, four in an inpatient hospital unit, and one study was conducted in a nursing home.	non-significant results.	
How to communicate with patients about future illness progression and end of life: a systematic review	Parry, Land, & Seymour	2014	The aim of the study was to explore how clinicians communicate about future illness progression and end-of-life.	Systematic review of 19 studies.	Ten of the studies concerned medical consultations, seven were on counselling sessions, one study was about family telephone conversations, and one study was about informed consent appointments for a randomized controlled trial.	The review found that conversations about illness progression and end-of-life can be initiated and pursued in a variety of ways and result in different consequences. For example, fishing questions and indirect talk were found to be sensitive communication practices but can make it easy for patients to avoid engaging in important topics. Hypothetical	**Strengths**: Useful in describing various communication practices that are effective in discussing difficult topics with patients. Many of the included studies offered data that is usually less accessible because of its publication in non-clinical fields. **Limitations**: Included several older

						questions were found to encourage conversation about specific topics.	studies with data that is more than 20 years old, making it potentially inapplicable to today's context.
Conceptual foundations of a palliative approach: a knowledge synthesis	Sawatzky, Porterfield, Lee, Dixon, Lounsbury, Pesut, Roberts, Tayler, Voth & Stajduhar	2016	The aim of the synthesis was to provide conceptual clarity in regard to a palliative approach to care, which includes serious illness communication.	Knowledge synthesis of 91 quantitative and qualitative research.	**Sample:** Individuals in the study had a variety of health conditions including multiple chronic diseases, cancer, dementia, COPD, neurological diseases, AIDs, renal disease, frail elderly, and congestive heart failure. **Setting:** Hospital, residential, home and community, hospice care, and education.	Three themes were identified: 1) an upstream orientation towards the needs of individuals with life-limiting conditions and their families; 2) adaptation of palliative care knowledge and expertise; 3) integrating a palliative approach into systems that do not specialize in palliative care. Findings indicate that there is a misalignment between the concept of palliative care and	**Strengths**: The search strategy utilized was clearly outline. **Limitations:** There was no quantitative synthesis of data. However, qualitative synthesis was used to achieve a higher level of abstraction.

						how it is currently offered in the healthcare system. Clear communication throughout the illness trajectory is essential, particularly in relation to conversations about advance care plans, goals of care, and "breaking bad news".	

Undergraduate Nursing Education in End-of-Life Communication

Study	Study Authors	Date	Research Question(s) and/or Aim(s)	Methodology	Setting and Sample	Main Findings of Relevance for Present Study	Critique
Providing direction for change: assessing Canadian nursing students learning needs	Brajtman, Fothergill-Bourbonnais, Casey, Alain, & Fiset	2017	The aim of this study was to examine the current curriculum content and learning needs of fourth year	Cross-sectional survey. Students completed the Palliative Care Quiz for Nursing (PCQN) and Frommelt's	**Sample:** 58 Anglophone and Francophone fourth year graduating nursing students.	One third did not feel adequately prepared to care for dying patients, particularly in regard to communicating with patients and	**Strengths:** Data was collected in several different ways: key informant interviews, two questionnaires,

			graduating nursing students related to end-of-life care.	Attitudes Toward Care of the Dying Scale (FATCOD). Key informant educators were interviewed for their knowledge of the curriculum and experience of teaching in the undergraduate program.	**Setting:** Canadian university (unspecified).	their families at the end-of-life. Clinical educators expressed concerns in students' knowledge of what to do and how to communicate in actual clinical settings around seriously ill and dying patients. Although end-of-life education was integrated throughout the program, the emphasis was dependent upon the commitment of individual professors and clinical instructors with experience or knowledge in this area.	open-ended questions. **Limitations:** Limited student responses. Data was collected from one single Canadian university, not representative of all Canadian universities. Retrospective nature of study relied on students' memories over the last 4 years
"I See My Mother's Face": Student nurse experiences caring for cancer patients	Sanford, Townsend-Rocchiccioli, Quiett & Trimm	2011	The aim of the study was to describe the experiences of nursing	Descriptive, qualitative design. Data was collected through three	**Sample**: 15 undergraduate nursing students who had provided	Four themes: caring for patients and families, interactions between students and healthcare	**Strengths**: Steps for maintaining rigor in the study were identified.

			students caring for cancer patients.	semi-structured focus group interviews.	care for at least one patient with cancer during their clinical placements. **Setting**: One university (unspecified)	providers, student experiences with dying patients, and students' prior experiences with cancer. Student described situations where little to no advance care planning and goals of care communication had been provided for cancer patients. These situations were found to be distressing to students. Students identified role play, case scenarios and exposure to cancer patients in a less stressful environment as useful education interventions	Purposive sampling was used in the study. **Limitations**: Qualitative research is subjective and thus there is little generalizability of the study findings. Additional focus groups and data triangulation of interviews and observations of students during clinical experiences would strengthen the findings.

Nursing student experiences of death and dying during a palliative care clinical placement: Teaching and learning implications	Gallagher, Saunders & Tambree	2014	The aim of the study was to explore nursing students' experiences of death and dying during a palliative care clinical placement and in their personal lives	Exploratory study using survey method. Data was collected through an online survey distributed via email after the completion of their clinical placement.	**Sample**: Convenience sample of 17 students who had done a placement in a hospital Palliative Care Unit. **Setting**: Two university nursing programs in Australia.	Caring for dying patients provoked feelings of sadness, anxiety and powerlessness. Two thirds of nursing students answered that they were considering palliative care as a future work place. Majority of students identified communication with patients and families to be the most transferable skill to other clinical settings.	**Strengths**: Survey used had both quantitative and qualitative component which strengthened the data collected. **Limitations**: Small sample size of 17 students from two universities. The study used student self-reports to measure exposure to death which could have been affected by recall bias.
Undergraduate nursing students' attitudes and preparedness toward caring for dying persons- A longitudinal study	Henoch, Melin-Johansson, Bergh, Strang, Ek, Hammarlund, Hagelin, Westin, Osterlind, & Browall	2017	The aim of the study was to describe the development of nursing students' attitudes toward caring for dying patients and their perceived preparedness	Longitudinal study. The students completed the Frommelt Attitude Toward Care of the Dying Scale (FATCOD) questionnaire at the beginning of first and second year, and at the end of their	**Sample:** 117 undergraduate nursing students. **Setting**: Six universities in Sweden with 3 year nursing programs.	The study found that overall attitudes change positively throughout students' undergraduate degree. Communication was viewed as an important issue in palliative care education, yet students' attitudes	**Strengths**: Longitudinal design was useful in evaluating the way that attitudes changed throughout students' studies. **Limitations:** Small sample size. Content of the education programs were

			to perform end-of-life care.	third year of education.		related to the specific items about communication did not change significantly in the study.	not compared across the universities.
Third-year nursing students' lived experience of caring for the dying: a hermeneutic phenomenological approach	Ranse, Ranse & Pelkowitz	2018	The aim of the study was to explore nursing students' lived experience of caring for a dying patient and their family.	Hermeneutic phenomenology	**Sample**: Six students **Setting**: One Australian university (unspecified)	Three themes were identified: being caring, unexpectedness in witnessing an expected death and experiencing loss. A lack of knowing what to say to patients and families experiencing loss was consistently noted in student nurses' narratives in the study.	**Strengths**: Recommendations for education, practice, and research were made based on the findings. **Limitations**: Small sample size and purposive sampling makes it difficult to generalize findings.

New Graduate Nurses' Perspectives on Engaging in End-of-Life Communication

Study	Study Authors	Date	Research Question(s) and/or Aim(s)	Methodology	Setting and Sample	Main Findings of Relevance for Present Study	Critique
Dealing with end of life—New	Croxon, Deravin & Anderson	2018	The study explored the perceptions of	Qualitative interpretative study with data	**Sample:** Seven new graduate nurses	Four themes identified: the role of the new	**Strengths**: The study results

graduated nurse experiences			new graduate nurses around their readiness for practice when faced with death and dying within the workplace, particularly in rural hospitals and community nursing settings.	collected in seven semi-structured interviews.	who had graduated within the previous two years. **Setting:** All of the new graduate nurses were working in areas which were not designated as palliative care positions, yet they found themselves caring for people at the end of their lives. This sample included nurses working in a variety of rural settings (base hospitals, Multi-purpose services and small hospitals).	graduate in palliative care, preparation for palliative care in undergraduate nursing curricula, readiness for dealing with death and dying, and gaps in educational preparation. The nurses all felt that palliative care was an important part of their work as new graduates and that it was relevant in a variety of nursing settings. Most graduate nurses acknowledged the importance of end-of-life conversations, although few felt confident in their role or adequately prepared in this skill. Particularly, communicating with families was viewed as being	included rich quotes said by the participants during the interviews which supported the findings well. **Limitations**: The study did not include much description of the demographic of the nurses included in the study such as the program they completed, and amount of time practicing.

						the most challenging aspect of end-of-life care.	
How new graduate nurses experience patient death: A systematic review and qualitative meta-synthesis	Zheng, Lee, & Bloomer	2016	The aim of the review was to get a deeper understanding of the experiences and emotions that new graduate nurses might have when facing patient death. **Questions**: 1)What are new graduate nurses' experiences (both positive and negative) of patient death? 2)What are the attitudes to caring for dying patients? 3) What are the impacts of patient death on new graduate nurses? 4) What recommendations for clinical practice and	Systematic review and meta-synthesis. Five published qualitative studies and one mixed-methods study were selected for the review. The studies were appraised using the CASP appraisal.	**Sample**: New graduate nurses working in various settings. **Setting**: Four studies included participants from an acute hospital setting, one included participants in the intensive care setting, and one study included participants from the palliative care setting.	Six themes were identified including: emotional experiences, facilitating a good death, support for family, inadequacy on end-of-life care issues, personal and professional growth and coping strategies. There are a variety of feelings and challenges experienced by new graduate nurses when faced with patient death.	**Strengths**: Strong methodology that included critical appraisal of studies and a clear strategy for analyzing the papers. **Limitations**: There was little demographic data on the population of graduate nurses that were included in each study. Most reported how long the population of nurses had been practicing but no other characteristics were provided.

			future research can be derived from these included studies?				
Finding the right words: the experience of new nurses after ELNEC education integration into a BSN curriculum	Barrere & Durkin	2014	The aim of this study was to explore the lived experiences of new graduate nurses caring for a dying patient who received specific end-of-life education content in their nursing programs.	Phenomenological study. Open-ended semi-structured interviews were taped.	**Sample**: Twelve new graduate nurses who had been in practice for approximately one year and had cared for dying patients in a variety of settings. **Setting**: One university setting (not specified).	End-of-life communication was found to be particularly challenging because nurses were still in the process of mastering basic nursing care while also needing to provide complex end-of-life care to their patients. A common theme amongst the nurses was difficulty finding the right words to comfort patients and families during the dying process. New nursing graduates who had participated in an end-of-life course as students were	**Strengths**: The process of ensuring rigor in the study was clearly outlined. New graduate nurses were selected from a variety of settings which brought different perspectives and rich narratives to the study findings. **Limitations:** Small, purposive sampling.

						able to provide quality end-of-life care in their first experience with a dying patient.	
Are newly graduated nurses ready to deal with death and dying? - A literature review	Malone, Anderson, & Croxon	2016	The review aimed to explore the readiness of students and new graduate nurses when faced with death and dying within the workplace.	Systematic literature review on research articles from peer reviewed journals. 31 articles were selected.	**Sample**: New graduate and undergraduate nurses. **Settings**: Workplace or clinical placement.	Four themes: the importance of palliative care in undergraduate nursing curriculum, readiness for dealing with death and dying, the death experience for different patient populations and education strategies. The review found that there is an increased emphasis on education strategies to assist with end-of-life knowledge and skills for nursing students.	**Strengths**: Search strategy was clearly outlined with a PRISMA flow diagram. **Limitations**: No demographic information about the nurses and no description of the setting in which nurses were working. No reference to how critical appraisal of selected articles was conducted.

Education Initiatives

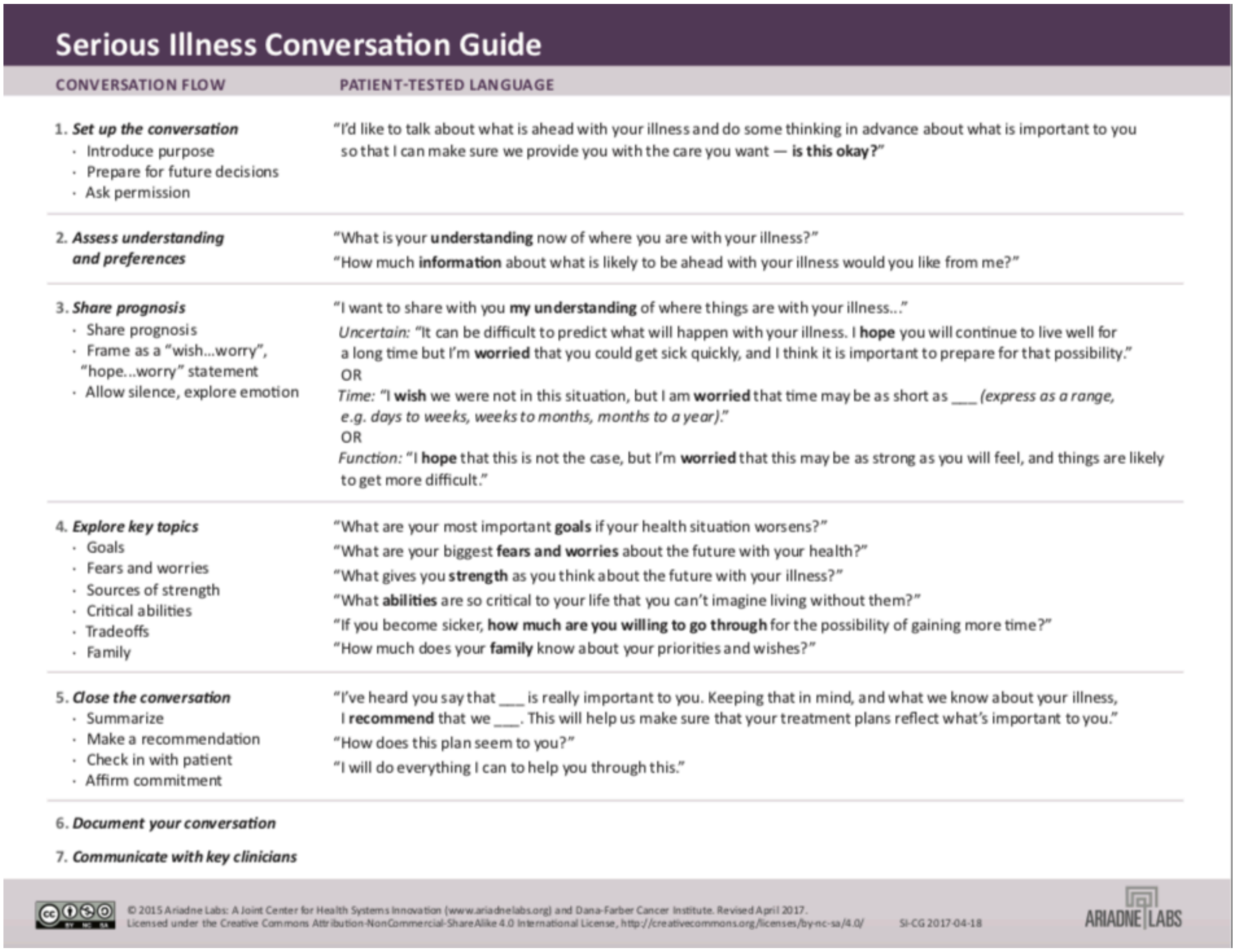
Study	Study Authors	Date	Research Question(s) and/or Aim(s)	Methodology	Setting and Sample	Main Findings of Relevance for Present Study	Critique
Educational interventions to train healthcare professionals in end-of-life communication: a systematic review and meta-analysis	Chung, Oczkowski, Hanvey Mbuagbaw, & You	2016	The aim of the study was to evaluate the effectiveness of educational training interventions for healthcare professionals in end-of-life communication skills.	Twenty articles that were either randomized controlled trials or prospective observational studies with a control group were selected for review.	**Setting**: Most of the studies were conducted in various settings in the United States. **Sample**: The studies were aimed at a variety of disciplines including medical trainees, postgraduate medical trainees, nurse practitioners in acute care programs.	Overall, the review suggests that end-of-life communication training may improve healthcare professionals' self-efficacy and knowledge compared to usual teaching. Self-efficacy was found to be the most common outcome measured in the studies. The review found that the communication skills outcome was the most relevant in capturing the construct of end-of-life decision-making communication.	**Strengths**: Study characteristics are clearly and thoroughly outlined in the review and in table format. The review has a strong methodology that included critical appraisal of studies and a clear strategy for analyzing the papers. **Limitations**: Only low to low quality evidence based on critical appraisal of the studies using the

							Medical Education Research Study Quality Instrument Scale (ERSQI) and the Newcastle-Ottawa Scale Education (NOS-E).
The effectiveness of communication-skills training interventions in end-of-life noncancer care in acute hospital-based services: A systematic review	Lord, Clark-Carter, & Grove	2016	The aim of the study was to explore the effectiveness of end-of-life communication-skills training interventions with noncancer patients in an acute health setting.	Systematic review. Ten articles were selected for review, all quantitative studies and mixed-methods studies.	**Sample**: There was a variety of healthcare professionals for participants, including registered nurses, healthcare assistants, consultants, and medical trainees. **Setting**: Nine studies delivered the intervention in a healthcare setting, and one study was a two-day retreat for	The review found that few studies have focused on end-of-life communication-skills training in noncancer acute-based settings. Based on the published studies, communication-skills training interventions were found to have positive effects on staff behavior with regard to communication about the end-of-life with patients and families.	**Strengths**: Search strategy was easy to follow with clear inclusion and exclusion criteria outlined. **Limitations**: The reviewed articles scored only moderately or weakly on quality based on the McMaster Quality Assessment Tool for

					participants away from the healthcare environment.		Quantitative Studies that was used to critically appraise the studies.

Appendix C

Serious Illness Conversation Guide



Serious Illness Conversation Guide

CONVERSATION FLOW	PATIENT-TESTED LANGUAGE
1. ***Set up the conversation*** · Introduce purpose · Prepare for future decisions · Ask permission	"I'd like to talk about what is ahead with your illness and do some thinking in advance about what is important to you so that I can make sure we provide you with the care you want — **is this okay?**"
2. ***Assess understanding and preferences***	"What is your **understanding** now of where you are with your illness?" "How much **information** about what is likely to be ahead with your illness would you like from me?"
3. ***Share prognosis*** · Share prognosis · Frame as a "wish…worry", "hope…worry" statement · Allow silence, explore emotion	"I want to share with you **my understanding** of where things are with your illness…" *Uncertain:* "It can be difficult to predict what will happen with your illness. I **hope** you will continue to live well for a long time but I'm **worried** that you could get sick quickly, and I think it is important to prepare for that possibility." OR *Time:* "I **wish** we were not in this situation, but I am **worried** that time may be as short as ___ *(express as a range, e.g. days to weeks, weeks to months, months to a year)*." OR *Function:* "I **hope** that this is not the case, but I'm **worried** that this may be as strong as you will feel, and things are likely to get more difficult."
4. ***Explore key topics*** · Goals · Fears and worries · Sources of strength · Critical abilities · Tradeoffs · Family	"What are your most important **goals** if your health situation worsens?" "What are your biggest **fears and worries** about the future with your health?" "What gives you **strength** as you think about the future with your illness?" "What **abilities** are so critical to your life that you can't imagine living without them?" "If you become sicker, **how much are you willing to go through** for the possibility of gaining more time?" "How much does your **family** know about your priorities and wishes?"
5. ***Close the conversation*** · Summarize · Make a recommendation · Check in with patient · Affirm commitment	"I've heard you say that ___ is really important to you. Keeping that in mind, and what we know about your illness, I **recommend** that we ___. This will help us make sure that your treatment plans reflect what's important to you." "How does this plan seem to you?" "I will do everything I can to help you through this."
6. ***Document your conversation***	
7. ***Communicate with key clinicians***	

SI-CG 2017-04-18

ARIADNE LABS

Appendix D

Preparatory Readings and Resources

Engaging Nursing Students in Serious Illness Conversation Training

This learning opportunity is supported by a grant to promote Experiential Learning in Academic Programming by the MacPherson Institute, McMaster University.

You are now enrolled in the Serious Illness Conversation workshop to be held Wednesday, January 9th 2019 from 8.30-12.00 at the McMaster Innovation Park, Room 1CD. We are providing some more information about the workshop and some pre-workshop activities to help you get the most out of the workshop. A reminder with further details and instructions for getting to the workshop will be sent closer to the date of the workshop.

Course Code and Title: N4K10 *Professional Practice and the New Graduate*

The **Serious Illness Conversation Guide** (SICG) and training workshop was developed in response to critical gaps in patient experience and care and for communication training of all health care professionals. Health care institutions such as Hamilton Health Sciences and the BC Cancer Agency have embraced the SICG as key to providing high quality care to patients coping with serious illness and end-of-life issues in community-based and acute care settings.

The SICG workshop is based on current evidence from communication in serious illness and adult education principles. The course materials have been tested and revised by Ariadne Labs which is affiliated with Harvard University. The workshop will be led by nurses who are trained Serious Illness Conversation facilitators.

This initiative provides nursing students with the opportunity to engage in experiential learning that is critical to future nursing practice and as a new graduate. The SICG workshop is designed to build on foundational communication skills students have learned in their BScN program and enhance their ability to achieve inter-professional health professions communication competencies.

Learning Outcomes:

Students who participate in the workshop will:

1. Understand the need for serious illness conversations with patients within the context of the nursing role, and from a patient and system perspective.
2. Develop an appreciation of the systematic approach to Serious Illness Conversations that focuses on patient values and priorities in serious illness.
3. Become familiar with the elements of the Serious Illness Conversation Guide.
4. Facilitate a serious illness conversation using the *Serious Illness Conversation Guide* and *Serious Illness Care Program Reference Guide for Interprofessional Clinicians*.
5. Engage in self and peer assessment.
6. Consider how the SICG could be used in their future nursing practice.

Students will receive a certificate in Serious Illness Communication training that can be added to their resumes.

The Serious Illness Conversation Student workshop has been approved by the Dr. Joanna Pierazzo, Assistant Dean (interim) Undergraduate Program in the School of Nursing.

Participation will be credited as 4 hours of learning in the professional practice course, *N4K10, Professional Practice and the New Graduate*.

Pre-Workshop Activities:

1. From Level 3: Review the *Joint Position Statement: The palliative approach to care and the role of the nurse:* https://www.cna-aiic.ca/~/media/cna/page-content/pdf-en/the-palliative-approach-to-care-and-the-role-of-the-nurse_e.pdf

2. Watch the following short video that focuses on some key points for all clinicians with regards to having conversations with seriously ill patients. Consider the meaning of this message for nursing practice.

   How to Talk End-of-Life Care with a Dying Patient - Atul Gawande (3.01 min) https://www.youtube.com/watch?v=45b2QZxDd_o

3. The following 2 videos from Ariadne Labs are examples of serious illness conversations between physicians and patients. Nurses and other health professionals are also encouraged to have these conversations that focus on patient values and goals. The workshop will help you develop skills to have serious illness conversations with patients and their families.

Please watch one of the following videos and reflect on the techniques, terms/words and responses that were used by the clinician and the dynamic that is created between the clinician and the patient. Consider how this approach could be integrated into nursing practice.
An Expert Conversation using Serious Illness Guide (20:04 min)

https://www.youtube.com/watch?v=xLl1HlCcNYM

https://www.youtube.com/watch?v=fhwa9f5O_U4

4. Read the following articles and consider your own experiences with serious illness communication personally and/or in your nursing practice. What do you anticipate to be the possible opportunities and challenges for you to have serious illness conversations with patients and their families?

   Bernacki, R.E., Block, S.D., for the American College of Physicians High Value Care Task Force. (2014). Communication About Serious Illness Care Goals A Review and Synthesis of Best Practices. *JAMA Internal Medicine*, 174 (12), 1994- 2003. doi:10.1001/jamainternmed.2014.5271
   https://www.ncbi.nlm.nih.gov/pubmed/25330167

Strachan, P.H., Kryworuchko, J., Nouvet, E., Downar, J., You, J.J. (2018). Canadian hospital nurses' roles in communication and decision-making about goals of care: An interpretive description of critical incidents. *Applied Nursing Research,* 40(April), 26-33. doi.org/101016/j.apnr.2017.12.014
https://www.ncbi.nlm.nih.gov/pubmed/2957949

5. If you have questions or require further information please contact

Bailey Jensen jensob1@mcmaster.ca
OR
Dr. Patricia Strachan strachan@mcmaster.ca

Appendix E

UNEC Approval Application

TITLE OF RESEARCH PROJECT

UNDERGRADUATE NURSING STUDENTS & SERIOUS ILLNESS COMMUNICATION

INVESTIGATORS (FACULTY/STUDENTS)

Principal Investigators:

Dr. Patricia Strachan (faculty)

Rachel Morkunas (MSc Nursing-Thesis Stream)

ACADEMIC INSTITUTION AND DEPARTMENT

McMaster University- School of Nursing

1. DURATION OF RESEARCH PROJECT

Start Date: January 1, 2018

End Date: June 30, 2019

2. DATA COLLECTION PERIOD

Start Date: January 1, 2019

End Date: May 30, 2019

3. STUDENT PARTICIPATION

a. *Please provide details regarding the type of student you seek to use in your research, student level, sample size, program sites, and terms in which students will be accessed (e.g., all Level I basic students from all 3 sites in the 2016 winter term; 50 Level III basic students and 50 Level III post-RPN students at McMaster in 2017 fall term and 2018 winter term).*

I will recruit full-time fourth year undergraduate nursing students from the McMaster site who have attended the Serious Illness Conversation Guide (SICG) workshop (provided in January 2019). These students will be enrolled in N4K10, Professional Practice and the New Graduate at McMaster University. It is estimated that 8 to 15 participants will be needed to reach data saturation.

b. *How will students be recruited? (e.g., posters, email)*

The researchers will forward a recruitment email to all eligible fourth year nursing students who participated in the SICG workshop and who consented to be contacted for follow-up. Students will be asked to contact the researcher (R. Morkunas) by phone or email if they are interested in participating. Study information will be shared directly with participants, and if they are interested in the study, permission will be obtained to contact them through their school email address to arrange one audio recorded interview at the site of their choice.

c. *What data collection method(s) will you use and how often? (e.g., one time on-line survey; two focus group interviews)*

One semi-structured interview will be conducted with each student participant. The interviews will be audio-recorded and then transcribed by the researcher (R. Morkunas). Participants will be offered to meet in a neutral and private location of their preference. Open-ended questions will be used following an interview guide. Student will be asked to complete a brief demographic questionnaire.

d. *What time commitment is required of students? (e.g., 30 minutes to compete on-line survey; 2 hours for first focus group and 1 hour for second focus group)*

The interviews will be approximately one hour in length, with additional time allotted if it is required by the participant to fully describe their experiences.

NOTE: NO STUDENTS MAY BE RECRUITED DURING CLASS TIME FOR ANY REASON

4. SUMMARY OF PROPOSED RESEARCH – 1 PAGE LIMIT (DOUBLE SPACED)

Please briefly describe your research objectives, question(s), and methodology.

This proposed research is in partial fulfillment of the requirements of the thesis portion of the Masters of Science in Nursing program at McMaster University.

While serious illness care is viewed as an important aspect of undergraduate nursing education, it is recognized as an area of practice for which undergraduate nurses feel they are not adequately prepared. In particular, communication with patients and families is reported as the most challenging aspect of caring for dying patients (Croxon et al., 2018).

Research objectives: The purpose of this study is to explore undergraduate student nurses' experiences of engaging in serious illness communication at their professional practice placements and to understand their use of and the perceived influence of the Serious Illness Conversation Guide training. Exploration of this phenomenon will be used to inform future integration of appropriate educational resources for undergraduate student nurses to support their engagement in serious illness conversations with patients and families.

Research questions: The overarching research question is "In what ways do fourth year undergraduate nursing students who have participated in SICG training experience engagement in serious illness communication in professional practice placements?” Two sub-questions were identified:

3. What are the perceptions of fourth year undergraduate nursing students about the ways in which the SICG training has influenced their professional practice?
4. What recommendations do fourth year undergraduate nursing students who have participated in SICG training have with regards to the SICG training in the undergraduate nursing curriculum at McMaster University?

Methodology: Interpretive description (ID) is a qualitative methodology that is useful when exploring the health and illness experiences of people from an applied health perspective. ID was selected to address the research questions because it allowed for both description and interpretation of nursing students’ shared experiences of the phenomenon, while generating findings that remain applicable to clinical practice (Thorne, 2016).

The researchers will forward a recruitment email to all eligible fourth year nursing students who participated in the SICG workshop and who consented to be contacted for follow-up. Twenty students will participate in the SICG workshop (January 2019), and of those students, it is estimated that 8 to 15 participants will be needed to reach data saturation. If students are interested in participating in the study, permission will be obtained to contact them through their school email address to arrange one semi-structured interview at the site of their choice. Open-ended questions will be used following an interview guide. Student will be asked to complete a brief demographic questionnaire. The interviews will be audio-recorded and then transcribed by the researcher (R. Morkunas). Interviews will be analyzed using a code book that will be developed to reflect emerging themes and trends that appear in the interviews. The research findings will be written in a thesis. The intention is to submit an article for publication and present findings in a conference. The research findings will also be made available to the McMaster BScN program.

Appendix F

Initial Contact Form

Rachel Morkunas, a student in the Masters of Science in Nursing thesis program here at McMaster University is conducting a study to follow-up from the Serious Illness Conversation workshop you attended. She is supervised by Dr. Patricia Strachan. Participation would involve a one-time interview with individual participants from this workshop.

If you are interested in being contacted to hear more about the research study and possibly participating, please contact:

Rachel Morkunas (morkunra@mcmaster.ca)

Appendix G

Email Invitations

Dear Nursing Student,

My name is Rachel Morkunas and I am a Master of Science in Nursing (MSc) student at McMaster. I am supervised by Dr. Patricia Strachan. I am inviting you to participate in a research study called Undergraduate Nursing Students' Experiences Engaging in Serious Illness Communication and Perceptions of Serious Illness Conversation Guide Training. The purpose of this study is to explore and develop an understanding of undergraduate student nurses' experiences of engaging in serious illness communication in their professional practice placements and to determine if they find the Serious Illness Conversation Guide training useful in these placements. I would like to give a voice to nursing students regarding this experience and use it to help inform the integration of appropriate educational resources.

You have been invited to participate in this study because you are a fourth year undergraduate nursing student who has completed Serious Illness Conversation Guide training. If you agree to participate in the study, you will be invited to an interview with me about the relevance of the training to your practice and explore if and how you have used it in total or in part. During the interview, you will be asked to talk about experiences about one or several memorable conversations with patients living with serious and/or their families. Each interview will be audio-taped and will take approximately 30 to 60 minutes to complete. The interview will take place at a convenient time and location for you. A $10 gift card to Tim Horton's will be offered to thank you for your time.

The information collected will be kept strictly confidential and you will be asked to sign an informed consent form to participate. You can stop the interview at any time and refuse to answer any questions. If you would like to participate or want more information, please contact me at 289-990-3015 or morkunra@mcmaster.ca. Thank you for your time and consideration!

Rachel Morkunas, RN
Student Investigator
MSc Student, McMaster University, School of Nursing
289-990-3015
morkunra@mcmaster.ca

Dr. Patricia Strachan, RN, PhD
Thesis Supervisor
Associate Professor, School of Nursing
McMaster University
(905) 525-9140 ext. 26157
strachan@mcmaster.ca

Appendix H

Undergraduate Student Nurse Semi-Structured Interview Guide

Thank you for agreeing to talk with me today. This study is being conducted to develop an understanding of undergraduate student nurses' experiences of engaging in serious illness communication in professional practice placements. I'd like you to think back to the Serious Illness Conversation workshop that you attended in January. At that time, you were introduced to the Serious Illness Conversation Guide and resource materials. I'd like to talk to you about if and how you have used the workshop and/or guide in whole or in part at your professional practice placement.

1. Tell me about your most recent professional practice placement.

Probes:

- Have you been involved with the care of patients with serious illness and/or their families?
- What was your role as student nurse?

2. Has there been a time when you have used the Serious Illness Conversation Guide either in whole or in part with a patient or family member?

- If yes, tell me about that experience?
- If no, go to Question 5

3. Tell me about an experience you've had as a student in this placement, when you communicated with a patient experiencing serious illness or their family.

Probes:

- What was the conversation about?
- What, if any cues did you notice?
- Do you remember what kind of emotional state the patient was in? What was that like for you?
- What was your relationship with this patient while you cared for them? Did you feel that you had a special connection with this patient or family?
- How long did you care for them?

4. How did you feel during this experience?

Probes:

- How long did these feelings last?
- How did these feelings or emotions change over time?
- Do you still think of this experience? If yes, what do you think about?
- What triggers these thoughts?
- What elements of this experience make you feel that it was a more positive or more negative experience?

5. Tell me about a memorable experience you had as a student in clinical placement, where you did not engage is a serious illness conversation but recognized that it could have been helpful?

Probes:
- Tell me about the result or outcome of this encounter?

6. When you think back to the workshop and communication training, was there anything that was particularly helpful to you in these situations?

Probes:
- How would you recommend that we integrate this training into the program (or not)?
- Is there anything that would have helped you feel better prepared to be in one of these situations, or in general in your practice?

Conclusion

Thank you for taking the time to share your experiences. Is there anything else you would like to add or elaborate on? Do you have any questions for me?

Appendix I

Participant Characteristics Questionnaire for Students

1. What is your age? ______________
2. What is your gender? Male ☐ Female ☐ Other _____________
3. What is your education experience prior to entering the BScN program? _____
4. Prior to receiving Serious Illness Conversation Guide (SICG) training, have you completed any formal training program focusing on palliative care or communication skills? Yes ☐ No ☐

   If yes, please specify which one: ________________
5. What is the setting of your N4K10 placement? ________________________
6. What was the setting of your previous level four placement? ______________
7. Do you have any current or previous volunteer/experience working with patients and/or their families experiencing serious illness? Yes/no. If so, please describe_______
8. Please rate your level of confidence from 7 (very confident) to 1 (very unconfident) in engaging in the following parts of the SICG with a seriously ill patient or their family member?

Setting up the conversation:

Extremely confident (7) Very confident (6) Somewhat confident (5) Neither confident nor unconfident (4) Somewhat unconfident (3) Very unconfident (2) Extremely unconfident (1)

Assessing illness understanding:

Extremely confident (7) Very confident (6) Somewhat confident (5) Neither confident nor unconfident (4) Somewhat unconfident (3) Very unconfident (2) Extremely unconfident (1)

Sharing information about the future:

Extremely confident (7) Very confident (6) Somewhat confident (5) Neither confident nor unconfident (4) Somewhat unconfident (3) Very unconfident (2) Extremely unconfident (1)

Allowing silence:

Extremely confident (7) Very confident (6) Somewhat confident (5) Neither confident nor unconfident (4) Somewhat unconfident (3) Very unconfident (2) Extremely unconfident (1)

Exploring emotion

Extremely confident (7) Very confident (6) Somewhat confident (5) Neither confident nor unconfident (4) Somewhat unconfident (3) Very unconfident (2) Extremely unconfident (1)

Exploring goals:

Extremely confident (7) Very confident (6) Somewhat confident (5) Neither confident nor unconfident (4) Somewhat unconfident (3) Very unconfident (2) Extremely unconfident (1)

Exploring fears and worries:

Extremely confident (7) Very confident (6) Somewhat confident (5) Neither confident nor unconfident (4) Somewhat unconfident (3) Very unconfident (2) Extremely unconfident (1)

Exploring sources of strength:

Extremely confident (7) Very confident (6) Somewhat confident (5) Neither confident nor unconfident (4) Somewhat unconfident (3) Very unconfident (2) Extremely unconfident (1)

Exploring critical abilities:

Extremely confident (7) Very confident (6) Somewhat confident (5) Neither confident nor unconfident (4) Somewhat unconfident (3) Very unconfident (2) Extremely unconfident (1)

Exploring tradeoffs:

Extremely confident (7) Very confident (6) Somewhat confident (5) Neither confident nor unconfident (4) Somewhat unconfident (3) Very unconfident (2) Extremely unconfident (1)

Documenting conversations:

Extremely confident (7) Very confident (6) Somewhat confident (5) Neither confident nor unconfident (4) Somewhat unconfident (3) Very unconfident (2) Extremely unconfident (1)

Communicating with key clinicians:

Extremely confident (7) Very confident (6) Somewhat confident (5) Neither confident nor unconfident (4) Somewhat unconfident (3) Very unconfident (2) Extremely unconfident (1)

Appendix J

Post-interview Contact Summary Form

Participant #:
Contact Date:

1. What were the main issues or themes that stood out in this interview?
2. Summarize the information obtained for each of the target questions.
3. Anything else that stood out as interesting, noticeable or important?
4. Are there any new or remaining questions to consider for the future?

Adapted from Miles & Huberman, 1994, p.53

Appendix K

Informed Consent Form

Study Title: Undergraduate Nursing Students' Experiences Engaging in Serious Illness Communication and Perceptions of Serious Illness Conversation Guide Training

Investigators:

Local Principal Investigator:	**Student Investigator**
Dr. Patricia Strachan	Rachel Morkunas
Associate Professor, School of Nursing	Graduate Student, School of Nursing
McMaster University	McMaster University
Hamilton, ON, Canada	Hamilton, ON, Canada
(905) 525-9140 ext. 26157	**289-990-3015**
E-mail: strachan@mcmaster.ca	E-mail: morkunra@mcmaster.ca

Funding Source: None

You are invited to participate in a graduate student research project conducted under the supervision of Dr. Patricia Strachan. This form will give you information to help you decide if you would like to participate in this study. This information will be discussed with you in person. Once you understand what is involved and are comfortable participating, you will be asked to sign this form.

What are we trying to discover?

The purpose of this study is to explore and develop an understanding of undergraduate student nurses' experiences of engaging in serious illness communication in their professional practice placements and to determine if they find the Serious Illness Conversation Guide training useful in these placements. This is important because effective and timely communication during the serious illness trajectory is helpful in ensuring that patients receive the care they want, in alleviating anxiety, and in supporting families. It is important that nurse leaders in the role of education understand the experience of their students so that they can provide them with the appropriate education and supports.

What will happen during the study?

If you volunteer to participate, you will be asked to take part in one individual interview. The interview will likely be 30 to 60 minutes long. You will be asked questions and to share stories from one or several memorable serious illness conversations with patients and their families during your final consolidation placement. You will also be asked to complete a short survey, with questions about things such as your age, gender and placement experience. You may be asked to participate in a follow up interview at a later time. With your permission, the interview will be recorded. The recording will be typed up and then deleted after the interview.

Are there any risks to doing this study?

It is unlikely that you will experience harm or discomfort during the study. You do not need to answer questions that you do not want to answer or that make you feel uncomfortable. You may stop to take a break at any time during the interview and you may stop taking part in the study at any time. There are no consequences to you if you decide to withdraw from the study. You may choose to withdraw some or all your data at any time during the study. You may refuse to answer any questions during the interview.

Are there any benefits to doing this study?

It is unlikely that the study will directly benefit you. However, you may find it therapeutic to discuss your experiences of engaging in serious illness communication in a safe, non-judgmental environment. Reflecting on your experiences may deepen your understanding about your own practice and the intentional use of the SICG. The results of this study may lead to improvement in education and the development of additional supports for student nurses in their professional practice placements.

Confidentiality

Any information obtained in connection with the study that might identify you or the patients that you cared for will remain confidential and anonymous. As the focus of this study is to describe the shared experiences of all participants, it is unlikely that specific personal experiences will be identifiable in the study. Demographic information, audiotapes, and transcribed interviews will be assigned an identification code and pseudonym and kept in a locked filing cabinet. Any digital data will be stored in a password-protected computer. Only the student investigator and study supervisor will have access to the information.

Payment or Reimbursement

You will receive a $10 Tim Hortons card to thank you for taking part in the study.

CONSENT

I have read the information presented in the information letter about a study being conducted by Rachel Morkunas and Dr. Patricia Strachan of McMaster University.

I understand the potential benefits and risks associated with the study.

I have had the opportunity to ask questions about my involvement in this study and to receive additional details I requested.

I understand that if I agree to participate in this study, I may withdraw from the study at any time. I have been given a signed copy of this form. I agree to participate in the study.

I would like to receive a summary of the study's results. Yes ☐ No ☐

If yes, where would you like the results sent:

Email: ____

Mailing address: ________________________________
____
____

Written consent of research participant:

Name of Participant (Printed)	Signature	Date

Consent form explained in person by:

Name and Role (Printed)	Signature	Date

Appendix L

Critical Incidents of Student Involvement in Serious Illness Communication

	Timing of CI	**Context**	**Nature of participant involvement in SIC**	**Participant response**	**Outcome**
CI 1	Pre-workshop	Surgical unit. Participant was working with primary nurse and caring for a patient who was a quadriplegic and expressed a desire to go home even though this was not a feasible option for him.	Participant followed the preceptor's example, did not address patient's concerns and didn't initiate a SIC.	Participant validated daughter's feelings but didn't know what else to say.	Participant felt that the conversation allowed the daughter to process some of her feelings.
CI 2	Pre-workshop	Medical floor. Patient with heart failure was having increasing hospital admissions and was very frustrated by her situation.	Patient initiated conversation with participant about her frustrations with her illness and current situation.	Participant didn't feel like it was their place to have a SIC as a student, instead they observed SICs that others had with parents when possible.	Many other members of the interdisciplinary team talked to the parents so ultimately the participant thought that the parents felt comfortable taking the baby home.
CI 3	Pre-workshop	Personal experience. Participant's grandma was admitted to an oncology floor and later to hospice.	Participant observed as the healthcare team had SICs with their grandma and outlined the different therapies available to her.	Participant felt "uncomfortable and useless". Listened to the patient's story but wished that she had probed more.	Participant always thinks back to this situation and wishes that they had engaged in SIC with patient.
CI 4	Pre-workshop	Medical floor. Pt had multiple readmissions and expressed	Participant watched family continue to give false hope to	Felt that the conversation was well done.	Felt that a statement made by the doctor relieved a lot of

		wanting to die. However, family was clinging onto hope and giving patient false hope.	patient but didn't engage in any kind of discussion with patient or family.		the burden from the patient's wife.
CI 5	Pre-workshop	Complex care unit. Had a patient with end-stage liver failure for 2 weeks during a placement.	Participant was task-focused and only engaged in "friendly talk" with the patient and her husband.	Participant felt that she could identify with the patient better because they were a similar age which helped guide the SIC.	Participant had an entire SIC with the patient following the SICG from memory.
CI 6	Pre-workshop	Trauma floor. Patient who had recently had a below the knee amputation because of her diabetes. Her other foot had become quite necrotic as well due to unmanaged diabetes.	Participant observed as the wound care nurse that they were shadowing engaged in a SIC.	Participant found it hard to engage in serious illness talk with the patient and husband because they were saying the bare minimum.	Never had a SIC with the patient or her husband, but feels that they would approach the situation differently post SICG workshop.
CI 7	Pre-workshop	Pediatric cardiology unit. Patient was a baby born with a cardiac defect that was so severe it was inoperable.	Participant was able to sit in on a family meeting where a conversation was had about the plan of care for the baby.	Participant felt that the conversation was a really good example of how to effectively tackle a difficult conversation. Liked that the nurse was very open and respectful with the patient.	Even though the wound care nurse didn't have a previously established therapeutic relationship with the patient, she was able to effectively have a SIC with the patient.
CI 8	Pre-workshop	Participant working with a wound care	Participant was encouraged by preceptor and	Participant felt that the meeting went well and	An open-ended conversation occurred and

		champion. Patient had an infected and unstageable ulcer. Patient's daughter not ready to make her mom "palliative" yet.	primary nurse to have a SIC with patient's daughter.	helped reassure and relieve the family that they were making the right decision for their baby.	the family was able to make a decision about their baby's plan of care.
CI 9	Pre-workshop	Long term care setting. Patient with advanced dementia who started to have acute abdominal issues, impacted.	Participant wondered if the patient was going to be sent to the hospital but came in the next day and found out that the patient had passed away.	Participant felt very nervous beforehand. As the SIC was happening, the daughter reacted and understood which encouraged participant to continue.	Daughter was receptive to the conversation and understood that the treatment options were limited.
CI 10	Pre-workshop	Long term care setting. Patient with multiple co-morbidities. Repeatedly admitted to hospital due to bowel obstructions. Patient wants treatment to be done in long term care setting but not appropriate for the setting.	Participant had a conversation with the patient about why it wouldn't be safe for her to have treatment for a bowel obstruction in the long-term care setting.	Participant was initially shocked that nothing had been done to "save" the patient. Then realized that it was the family's decision to keep her there.	The nurses had had a conversation with the patient's family previously and the decision to remain in the long-term care home aligned with their goals of care.
CI 11	Pre-workshop	Oncology setting. Patient with terminal end-stage cancer diagnosis. Patient's husband was very against taking a palliative approach to care.	Participant's preceptor supported them in having a conversation with husband about palliative supports that could be implemented to	Participant was not sure how to make the patient change her mind. Felt that the conversation would have been a good opportunity to	Participant was not able to change patient's mind regarding treatment but at least was able to communicate the risks to her and she listened.

		Patient quickly deteriorating and in a lot of pain.	make the patient more comfortable.	ask about patient's future goals and preferences were but didn't.	
CI 12	Pre-workshop	Oncology setting. Patient having their first round of chemo had a reaction to the chemo. Husband was present and became very emotional and upset.	Participant stayed with the patient and husband while their preceptor went to get materials to help with the reaction. Attempted to provide comfort to them.	During the conversation, participant felt like they didn't know what to say. Also felt that they could've left more space for silence.	Participant's preceptor said that the conversation was well done. Patient was ultimately transferred to a palliative unit.
CI 13	Pre-workshop	Neuro unit. Family meeting where the doctor explained the patient's poor prognosis to the family.	Participant observed family meeting and witnessed the SIC that the doctor attempted to have with the patient's family.	Participant had no idea what to say. Felt awkward and didn't know what to do to comfort the husband and patient.	Participant held the patient's hand and reassured the husband and patient as best as they knew how to which was likely helpful to the patient and husband in the situation.
CI 14	Pre-workshop	Neuro unit. Participant supervising a patient while they're walking up and down hallway.	Patient randomly mentions their husband's death during the walk. Participant doesn't respond to comment, moves on to another topic.	Participant felt that the doctor could have attempted to further explore the patient's wishes and preferences by asking the patient's family more specific and direct questions.	The family insisted that they wanted everything done for the patient and were not open to considering alternative options.
CI 15	Pre-workshop	Global health placement. Participant health	Participant attempts to reason with	Participant felt like she should've said	Participant ignored patient's

		teaching a patient about diabetes at a clinic. Patient in denial about having diabetes.	participant about managing their diabetes and inform them about the condition. Patient unwilling to accept that they have diabetes.	something or explored how the husband's death was impacting the patient's visit now.	comment and moved on with conversation.
CI 16	Pre-workshop	Medical floor. Patient with vulvar cancer considering transferring to a hospice setting.	Participant engaged in SIC with the patient by exploring her current level of comfort, trade-offs, and the different options available to her.	Participant perplexed as to how patients are unaware of their conditions.	Preceptor nurse told participant that in this setting they don't do health teaching.
CI 17	Pre-workshop	Medical floor. Patient with poor prognosis due multiple co-morbidities and patient's son extremely upset.	Participant acknowledged the son's feelings and validated them.	Participant second guessed themselves during the SIC because they didn't want to say the wrong thing but felt more confident with the support of their preceptor.	Patient was very receptive to the SIC. Ended up being moved to a local hospice.
CI 18	Pre-workshop	Medical floor. Patient in extreme pain. Multiple admissions to the hospital.	Participant observed as their preceptor inquired about the patient's spirituality and practices.	Participant didn't know what to say to make the son feel better and felt quite upset by the situation.	Participant was upset leaving clinical that day because they felt like they hadn't been helpful. Regarded the conversation as first exposure to a bad news conversation.
CI 19	Post-workshop	Seniors mental health unit. Participant had	Participant spoke to patient's daughter about	Participant validated daughter's	Participant felt that the conversation

		known patient and daughter for several months.	her coping abilities and caregiver burnout. Stated they used parts of the SICG to guide conversation.	feelings but didn't know what else to say.	allowed the daughter to process some of her feelings.
CI 20	Post-workshop	NICU. Parents taking baby home with a poor prognosis. Parents having difficulty accepting poor prognosis.	Participant didn't try the SICG with parents. Had a chance to observe a couple SIC parents had with other members of the interdisciplinary team.	Participant didn't feel confident enough to engage in SIC even though they recognized that something should've been said to the patient.	Participant felt bad about the situation afterwards. Felt that they should've spoken up as no one else had.
CI 21	Post-workshop	Medical floor. Patient admitted with a fall and then had aspiration pneumonia while in hospital. Patient's condition changing day to day.	Participant had a conversation with the patient's family about plan of care. Explained the uncertain illness trajectory. Used "bits and pieces from the guide [SICG]"	Participant felt something had to be said but didn't because felt like it was outside of their comfort zone and scope of practice as a student.	Recognized that this was patient who could've benefited from a SIC, need a proactive approach.
CI 22	Post-workshop	Medical floor. Patient admitted with CHF exacerbation and history of Alzheimer's. Rapidly declining after admission.	Didn't find a SIC documented anywhere so assumed that none had been had. However, didn't initiate one.	Felt confident and at ease due to patient's family being very calm and understanding.	Felt that the situation was complex due to the uncertainty of the illness. Patient and family receptiveness was a facilitator in engaging in SIC.
CI 23	Post-workshop	Psychiatric emergency. Young patient who came in after her formal	Participant started with small talk and then lead the	Participant thought that a conversation should happen	Patient passed away and the family was devastated because no one

		and was feeling suicidal.	conversation into a SIC.	but didn't initiate one.	had talked to them so they weren't expecting it.
CI 24	Post-workshop	ICU. Young patient with an unstable and fluctuating disease progression.	Family asked about the blood work results and later about the patient's prognosis and participant related this information to them. Described the uncertainty related to the prognosis.	Participant felt defeated. Appreciated that the healthcare team had emphasized that it was the patient's decision to make about which care route she preferred.	Looking back, participant felt that it was really good that the healthcare team did take the time to talk about things openly and honestly.
CI 25	Post-workshop	ICU. Patient coded 3 times in one hour and patient's daughter crying nonstop.	Observed the event.	Participant stated the facts and gave an honest answer but also described a lot of the uncertainty involved in the case.	Continued to have many conversations that were continuous so participant felt that SICs helped build a foundation for future conversations and decision making.
CI 26	Post-workshop	ICU. Nurse attempted to have a code status conversation with a patient's daughter.	Observed the event.	Participant felt that the whole situation was very emotional.	Social worker comforted the patient's daughter and talked to her.
CI 27	Post-workshop	ICU. Doctor had a code status conversation with a patient's wife.	Observed the event.	Participant felt that the conversation was done too abruptly, and that using open-ended questions in this	The patient's daughter reacted very emotionally to this conversation had to leave the room.

				conversation would have been helpful.	