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Realistic simulation as a teaching tool in critical situation communication in palliative care

Simulação realística como ferramenta de ensino na comunicação de situação crítica em cuidados paliativos

Simulación realista como herramienta de enseñanza en comunicación de situaciones críticas en cuidados paliativos

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ABSTRACT

Objectives: To identify the perception, skills and competencies of nursing students regarding the communication of the critical situation in palliative care through realistic simulation. **Method:** Qualitative and quantitative descriptive study, developed with 41 undergraduate Nursing students from a university in southern Brazil. Research conducted in the laboratory of simulated practices, between March and May 2019. **Results**: The average age of students was 23.4 years. Regarding their perception about communication of critical situation: 39% scored it as difficult; 75.6% never participated in communication in critical situations and; 36.6% feel quite stressed in this context. From the analysis of qualitative data, emerged two categories: Feelings and difficulties of the student facing the communication of critical situations in palliative care and; Main competences acquired through the teaching-simulation tool. **Conclusion and implications for nursing practice:** Clinical simulation is an important tool in the teaching-learning process, brings about observation and makes students confident in the ability to maintain interprofessional and family dialogues. It implies, in this way, in professional practice regarding decision making, in the communication of bad news.

Keywords: Simulation; Communication; Palliative Care; Nursing Education.

RESUMO

Objetivo: Identificar a percepção, habilidades e competências dos estudantes de enfermagem frente à comunicação da situação crítica em cuidados paliativos por meio da simulação realística. **Método:** Estudo descritivo quali-quantitativo, desenvolvido com 41 estudantes do Curso de Graduação em Enfermagem de uma universidade do sul do Brasil. Pesquisa realizada no laboratório de práticas simuladas, entre março e maio de 2019. **Resultados:** A média de idade dos estudantes era 23,4 anos. Quanto à percepção deles sobre comunicação da situação crítica: 39% pontuam como difícil; 75,6% nunca participaram de uma comunicação em situações críticas e; 36,60% se sentem bastante estressados nesse contexto. Da análise dos dados qualitativos, emergiram duas categorias: Sentimentos e dificuldades do estudante frente à comunicação de situações críticas em cuidados paliativos e; Principais competências adquiridas por meio da ferramenta de ensino-simulação. **Conclusão e implicações para a prática da enfermagem:** A simulação clínica é importante ferramenta no processo ensino-aprendizagem, faz emergir a observação e torna os estudantes confiantes na habilidade de manter diálogos interprofissionais e com a família. Implica, desta maneira, na prática profissional no tocante às tomadas de decisão, na comunicação de más notícias.

Palavras chave: Simulação; Comunicação; Cuidados paliativos; Educação em Enfermagem.

RESUMEN

Objetivos: Identificar la percepción, habilidades y competencias de los estudiantes de enfermería con respecto a la comunicación de la situación crítica en los cuidados paliativos a través de la simulación realista. **Método:** Estudio descriptivo cuali-cuantitativo, desarrollado con 41 estudiantes universitarios de enfermería de una universidad del sur de Brasil. Investigación realizada en el laboratorio de prácticas simuladas, entre marzo y mayo de 2019. **Resultados**: El edad promedio de los estudiantes era 23,4 años. En cuanto a su percepción de comunicar la situación crítica: el 39% califica como difícil; el 75,6% nunca participó en la comunicación en situaciones críticas y; el 36,6% se siente bastante estresado en este contexto. Del análisis de datos cualitativos, surgieron dos categorías: Sentimientos y dificultades del alumno frente a la comunicación de situaciones críticas en cuidados paliativos y Competencias principales adquiridas a través de la herramienta de enseñanza-simulación. **Conclusión e implicaciones para la práctica de enfermería**: La simulación clínica es una herramienta importante en el proceso de enseñanza-aprendizaje, hace emerger la observación y hace que los estudiantes confíen en la capacidad de mantener diálogos interprofesionales y familiares. Implica, de esta manera, en la práctica profesional sobre la toma de decisiones, en la comunicación de malas noticias.

Palabras clave: Simulación; Comunicación; Cuidado paliativo; Educación en Enfermería.

INTRODUCTION

Communication is the basis of relationships among beings, of these with the environment and with other living beings. It is established when there is understanding on the part of those involved in verbal, non-verbal and written messages, and requires multiple visual, oral, auditory and olfactory adaptation skills. Communication is described as the exchange of information and good understanding between people, involving sender and receiver. However, it is not always easy to establish clear and calm communication, especially when the health team is faced with the need to communicate with patient and family.[1]

The development of an effective communication must involve the opportune moment, being objective, clear, precise, complete, without ambiguities or roundabouts, avoiding the use of technical terms. Thus, it will be understood by the recipient, reducing the risk of errors and occurrences, providing security and quality in the relationship of the health team, family and patient. Communication in the health scenario encompasses different skills of the team, involves the cognitive ability acquired through attentive listening, perception, understanding and logical reasoning. Still, it covers verbal and non-verbal language and respect for others who are involved in the communication process.[1-4]

The health team is in direct contact with patient and family, sharing information, sending and receiving messages throughout their professional lives. Thus, it is essential to be prepared to conduct communication in the course of the care action. In this perspective, effective communication requires empathy and emotional intelligence, and this relationship can be directly affected by factors such as working conditions (permanent/temporary), lack of professional experience, personal or sociodemographic characteristics.[5]

The communication of critical situations in palliative care is an essential skill in the daily practice of nursing. The conditions of fragility and death and dying permeate the process of human living in different circumstances and stages of experience. Palliative care deals with the quality of care for a good death. And, professional training in communication in critical situations in palliative care is necessary, prudent, crucial and ethical, both for undergraduates and professionals. Professional preparation on this topic goes beyond informing the clinical picture, prognosis and treatment. It is necessary that the team knows the palliative philosophy, has the ability to understand the moment of the family and of the patient in the face of the new reality. Exercising empathy in all message exchanges.[6]

Realistic simulation is a valuable tool in a curriculum of active methodologies, allowing students to be exposed to common situations and with different degrees of complexity, similar to those they will encounter in practical experiences. It is possible to use simulation for the use of nurse-patient communication, communication of critical situations, interprofessional and multi-professional relationships, teamwork, stressful situations, among others.[7]

Educational approaches in academic-professional training in health, specifically for nurses, in the reality of this study, demand knowledge, skills and attitudes and methodological strategies that promote a leap from theory to effective practice. One of the strategies used to work on the communication of critical situations in palliative care is the clinical simulation with actors, since it provides the future professional with an approach to reality, stimulating attitudinal reflection through a practical example, with the possibility of transformation in the assistance and safety of the student in face of what precedes the assistance practice with the patient and the family. This pedagogical tool expands real experiences of practice, being a new path of safe, quiet learning, with the opportunity to rethink and reflect on positions, attitudes and decision-making, successes and adjustments.[6,8,9]

In this sense, "Nursing, increasingly, is faced with the challenge of preparing its professionals for the performance of technical and non-technical skills. Simulation, especially the scenic, with actors, has been recognized as an ally to the teaching-learning care with a view to patient safety, improving teamwork, reducing costs in the reality of work and emotional strengthening of students.[7]

Thus, the present study aims to: identify the perception of nursing students regarding the communication of critical situations in palliative care through realistic simulation with actors.

METHOD

Descriptive study with a quantitative and qualitative approaches, carried out in the Nursing Course of a University in southern Brazil. Developed from the simulation activity in the simulated practices laboratory, from March to May 2019, in the discipline Experiential Learning III. The discipline deals with the theme of death and dying and corresponds to the axis of the 5th curricular phase of critical health condition. The study population consisted of 52 students who met the inclusion criteria – students enrolled and taking the Experiential Learning III course. Exclusion criteria: students absent from the simulation activity. In a class prior to the simulation, the proposal was presented to the students to explain the research objectives and invite them to participate in this study. The study sample was formed at the end by 41 nursing students, since nine students were not present, due to absenteeism, in the simulated practice, and two did not attend the discipline.

The data collection technique took place in the clinical simulation scenario, in the simulated practices laboratory of the Nursing Course. The methodological flow is described in three moments: simulated activity; collection of quantitative data; collection of qualitative data.

To instrumentalize the development of the simulation, a clinical guide was organized using the strategy proposed by Fundación Progresos Salud Consejerá de Salud,[10] so that the simulated activity followed the steps: 1st Definition of the topics for theoretical discussion; 2nd Definition of the main competencies to be developed; 3rd Planning and development of content through pedagogical tools that enabled the participation of participants actively; 4th Development of theoretical activities with the help of professionals with expertise in the area; 5th Preparation of the clinical simulation guide; 6th Meeting with the actors to develop the briefing; 7th Organization of material and laboratory; 8th Division

of groups for simulation; 9th Presentation of the guide and the simulated environment to the participants; 10th Conducting the simulation; 11th Group debriefing; 12th Assessment of clinical simulation activity.

For the development of the simulation, students were divided into ten groups, with four students per simulation scenario in nine groups and one group with five students. The simulation stages lasted approximately 45 minutes per group, totaling five class hours. It is clarified that the steps 1 to 9 were performed by the teachers before the simulation. The other steps, from 10 to 12, refer to the simulated activity.

Three actors took part in the simulation and received the clinical guide a week in advance and promoted the rehearsal of the scene, according to the guidelines described. On the day of the simulation, through the briefing, the teachers reinforced the objectives of the activity to the actors. In the 10th stage (carrying out the simulation), the guidelines were made effective for the students, reminding the scenario and the condition of the patient and family, according to material available in the moodle system. The simulated event lasted 15 minutes, documented on video with the consent of the participants. The simulated scenario was composed of the elements necessary for the scene of a hospital stay, in a room of approximately four square meters, composed of a lighted environment, artificially ventilated, with simple materials: a bed, an auxiliary table, a nightstand, a chair for the companion, wall ornamented by valves for access to medicinal gases, support and bottles for fluid therapy.

The clinical guide described the story of a young man admitted to a hospital clinical unit, accompanied by his mother and sister, who received the news about the condition of palliative care, when diagnosed with cancer. The scenography was formed by the actor representing the patient lying on the bed with physiognomies of suffering and prostration, while the sister and mother, personified by two actresses, showed behavior of non-acceptance, of desolation.

The skills observed and identified in the realistic simulation activity were: verbal and non-verbal language; active listening; empathy; helping relationship and; development of communication tools (paraphrases, summaries, clarification, reflexes and emotions).

The 11th stage (debriefing) was carried out in an exclusive environment, with the presence of students (four in each simulation) and two teachers. For the development of this stage, the teachers used a data show, computer and speaker. The students saw the scene filmed and, subsequently, teachers and students developed the debriefing, lasting approximately 25 minutes per group. In debriefing, we sought to reflect with students on the skills developed about active listening, the tone of voice, respect for family time, the rhythm of language, as understood by people, the use of technical terms, the identification of feelings of pain and the importance of empathy. The 12th stage was to assess the clinical simulation activity, after the end of the debriefing.

At the end of the debriefing, the students answered two instruments: the first with 10 closed and structured questions and; a second instrument using the Likert model. The first instrument referred to the communication of bad news and the second, an assessment of the educational simulation strategy.

The questions related to the first instrument address: 1st Profile of the students (age, race, sex, religion and education level); 2nd How do you feel about the possibility of communicating the critical situation with the multi-professional team in palliative care to the patient and family? (Response options: tolerable, difficult and very difficult); 3rd How often have you participated in communication in critical situations in palliative care for the patient and family? (Response options: never, 01-04 times; 05-08 times); 4th What is your degree of stress regarding the communication of the critical situation in palliative care to the patient and family (Response options: little stressed; stressed and very stressed).

To answer the second instrument about the degree of contribution of the educational simulation strategy in the communication of critical situations in palliative care to patients and family (questions: 5 to 11), the Likert Scale was used, considering the scores between 0 to 04, where: 0 represents that there was no contribution; 01: reasonable contribution; 02: moderate contribution; 03: good contribution; 04: excellent contribution. The Likert scale is an instrument that proposes psychometric responses and presents variations in the score.[11]

A self-administered instrument was applied, with three open questions regarding the qualitative data collection, asking the participants to describe: what are the feelings that communication in a critical situation in palliative care to the patient and family arise in you; the main difficulties experienced by you when communicating the situation in palliative care to the patient and family; which are the most significant skills, developed in the simulation in palliative care, for patient and family.

For the treatment of quantitative data, these were organized in an Excel for Windows® 2003 program. Then, the calculation of relative frequencies (percentages), absolute frequencies (*n*) and average, median and standard deviation was developed.

The qualitative analysis process was based on content analysis.[12] This type of analysis allows the description of messages and attitudes that refer to the context of the enunciation. The three stages of content analysis were respected, in the pre-analysis, floating readings were performed to recognize the material made available, which allowed the textual clipping of the statements to be analyzed. In the second stage, of data treatment, categories were defined through the enunciation coding system, resulting in units of meaning due to similarity and frequency. What led to the third stage of treatment – interpretation and analysis of the data –, with the emergence of communication itself, as a hindrance to the approach to death, the lack of knowledge of the use of right and appropriate words, and attitudes towards the death of a patient and the family pain. The results indicate that the simulated strategy approaches reality, inciting the necessary perception and attentive and active listening to the needs of the patient and his/her family.

In view of the results of the quantitative and qualitative analyzes, the following categories emerged: Feelings and difficulties of the student facing the communication of critical situations in palliative

care in the clinical simulation and; Main competencies acquired through the teaching-simulation tool.

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RESULTS

The study included 41 students (n=41) from the fifth phase of the Nursing Graduation Course, average age (23.4 years); median (22 years); standard deviation (4.32 years). Of these students, n=36 (87.8%) are female, n=35 (85.36%) are white, n=17 (41.46%) are Catholic, n=37 (90.24%) are single, and all have incomplete higher education, none of them is graduated in another higher education course. With regard to issues related to the students' perception of the communication of the critical situation, n=17 (43.46%) of the students considered it tolerable, n=16 (39%) scored it as difficult and n=09 (21.95%) considered it being very difficult the possibility of communicating the critical situation together with the multi-professional team in palliative care to the patient and family. As for the frequency with which students participate in communication in critical situations in practice, n=31 (75.6%) of students never participated in communication in critical situations. With regard to stress when communicating the critical situation in palliative care, it was observed that n=15 (36.60%) of the students felt quite stressed and n=14 (34.14%) of them felt very stressed. As for the frequency with which the student participates in communication in critical situations in practice, it is highlighted that 75.6% (n=31) of students never participated in communication in critical situations. Regarding stress when communicating the critical situation in palliative care, it was observed that 36.60% (n=15) of the students felt quite stressed and 34.14% (n=14) of the students felt very stressed.

From the analysis of qualitative data, the following categories emerged: Feelings and difficulties of the student facing the communication of critical situations in palliative care in the clinical simulation and; Main competencies acquired through the teaching-simulation tool. Regarding the main difficulties reported by students in communicating the critical situation in palliative care, it is observed that the way of speaking implies the student's need to organize strategies that can help the patient and his/her family in minimizing the pain experienced when being informed about the critical situation in palliative care, present in the following statements:

> *I don't know what to say, how to act when they are emotionally altered* (S10).
>
> *I am concerned about their expressions and mood changes, I am afraid they will be sick* (S22).

The feelings that emerge in the communication of a critical situation in palliative care reinforce the difficulty of the human being in the face of death and of the process of dying, to resolve their conflicts, to accept the existential finitude. The students reported fear of the family's reaction, fear of not being able to help people and fear of "failing" in the face of the situation, as evidenced in the reports below:

> *I am afraid to deal with the reaction of the family, I feel helpless when they start screaming, they become aggressive and stressed* (S08).
>
> *I am afraid of not being able to help these people when feeling moved by the situation* (S02).
>
> *I am afraid of failing before these people; concerned about taking care of these people when I am also fragile* (S36).

The most difficult feelings to manage in daily care in a palliative situation are: denial, anger and guilt, which associated with the fear of speaking, when to speak and how to speak, cause insecurity in the speech of students regarding their own feelings regarding communication of the critical situation:

> *For me, the most difficult thing is to deal with anger and guilt, I wouldn't know what to say* (S33).
>
> *It is difficult to deal with them when they are denying all the time, they persist with the denial of what is real* (S13).

Regarding the skills achieved through realistic simulation as a teaching tool in communicating critical situations in palliative care, students report that verbal and non-verbal language was developed when they exercised active listening, silence, in addition to identifying non-verbal expressions presented by the patient and their family. Such situations are represented in the students' statements, as follows:

> *It was very interesting to realize how important it is to develop active listening* (S06).
>
> *It was very important for me to listen actively in this process, I didn't have much to say, just listening* (S18).
>
> *There was a time when it was not possible to speak, the family turned around, lowered their heads and had to stop talking* (S25).

The help relationship is perceived by the students through the need for respect, authenticity and empathy when communicating a critical situation in palliative care, expressed in the reports below:

> *There were moments when we just have to wait for the family's own time, the important thing is to respect their time* (S12).
>
> *I tried to put myself in their place, and gradually I understood what to do* (S07).

The communication tools (paraphrases, summaries, clarification, reflexes and emotions) were identified by the students when they understood the patient and family's feelings of pain, as well as when "clarifying" the information regarding their understanding of the information given by the team, manifested in the following statements:

> *I tried to understand, clarify what they already knew about palliative care* (S28).
>
> *I was able to identify various feelings such as guilt, anger, pain, fear and tried to show them through the reflexes of emotions* (S39).

With regard to the contribution of the educational strategy to the development of the proposed skills, it was observed in Table 1, that there was a higher score on the Likert Scale regarding the ability of active listening, average 3.75; median 4; and standard deviation 0.43 of the scores between 01 to 04, and empathy skills average 3.73; median 4 and: standard deviation 0.44.

DISCUSSION

Human relations are based on communication. Understanding or not the information communicated depends on the establishment of a bond, on the degree of knowledge between the peers, on what, when, how to speak, on the tone of voice, on the clarity of information and on the ability to perceive whether the other coded the message emitted.[1-4]

Health professionals have difficulties in dialoguing with patients and families, when the focus of this conversation is on difficult news. In view of this, circumstances and modes of communication need to be exercised, given the emotional and reactionary burden, both of family members and patients, and of health professionals. Notifying difficult messages brings constraints and uncomfortable feelings to the people involved in the communication action.[13]

Faced with such situations, in university practice, simulations and other educational strategies have provided the student with an approximation to reality, instrumentalizing these students and future professionals to care for patients and families in critical and palliative care situations, perpetuating learning and providing opportunities for professional growth.[14-16] In the referred study, students point out learning opportunities through approximation with reality, where they had the possibility to experience different knowledge to be applied in critical communication in palliative care through realistic simulation.

Students bring up the difficulties experienced in the dialogue with the family and with the patient, acquired in this educational practice. This, therefore, goes beyond the challenges proposed by the practice in hospitalization, the students identified suffering with the anticipated loss and the announced death. Studies indicate that any and all conversations of health professionals with the family are mixed by strong expectations of anguish, doubts and fears in the face of critical news. Such facts can be directly related to the lack of ability to deal with such situations.[5]

In the same way that the patient and family have difficulties in apprehending and accepting the path of the disease, of the care and its end, for the nurse, the doctor, the social worker, among other health professionals, the feeling of helplessness, fragility in the face of suffering, hinders communication and the professional/patient/family relationship. The main difficulties presented in the referred study by the students – which they point out as a stressful and difficult time to be experienced – agree with other studies already developed with health professionals in communication in palliative care, where they point out challenges in dealing with the suffering of others and with their own suffering, difficulties in understanding the feelings expressed by the patient and their

Table 1 - Evaluation of the skills acquired by the 41 participants. (Measurement: Likert scale). Florianópolis, SC, Brazil, 2019.

Skills	Average	Median	Standard deviation
Active Listening	3.75	4	0.43
Soft tone of voice	3.63	4	0.62
Respect for the family's time	3.63	4	0.62
Follow the rhythm of language according to people's comprehension	3.63	4	0.62
Understand the importance of empathy	3.73	4	0.44
Approach practice in a realistic way	3.48	4	0.67

Likert scale = 0 to 4; 0: there was no contribution; 01: reasonable contribution; 02 moderate contribution; 03: good contribution; 04: excellent contribution.
Source: Authors, Florianópolis 2019.

family, in addition to difficulties in dealing with their own emotions in the face of the feelings expressed by them.[6]

The main difficulties pointed out by students regarding the communication of the critical situation in this study reveal the uncertainty of when and how to talk about palliative care, combined with the difficulties in expressing communication. The anxiety and stress generated to students in this study during the simulation are expected feelings when dealing with the unknown. Studies show that, as students experience scenes that approach reality and are able to perceive the progress in the acquisition of skills, the anxiety and stress response decreases and the assuredness in the development of activities brings satisfaction to students.[17]

In this sense, the ability to communicate a critical situation is even more difficult, as the phrases need to be well placed to reduce the likelihood of being misunderstood or not understood by students.[18-20] Hence the importance and organization of strategies for coping and willingness of the students to strengthen the means to deal with their own feelings and emotions and overcome their own weaknesses. Academic training is evolving, with regard to the development of techniques and technologies, for dialogue in the dictates of humanization and sensitivity to attitudes of empathy and listening prior to the word. In this sense, the feedback that is carried out after the simulation offers objective evidence of how the students' resourcefulness occurred during the clinical simulation and allows, with the help of the teacher, that the students realize how they can improve their skills and attitudes in the face of the situation experienced.[21]

In the 1990s, Robert Buckman presented a protocol to direct critical situation communication. It refers to the Spikes protocol, which implies the competencies and skills to be developed by the health team in the management of critical situations, highlighting the need to observe the knowledge of the patient and his/her family about his/her condition; assess what the patient and family want to know about their diagnosis and condition; conducting information in a calm, welcoming and understandable manner; need to identify feelings and emotions, strengthening empathy. Thus, it is possible for health professionals to consider therapy and prognostic possibilities for adequate guidance that minimizes anxieties and gains the trust of the patient and family for adherence to treatment.[2]

In the proposal of this study, it is observed that the competencies and skills identified signal some of the competencies established in the Spikes protocol, since students point out the development of active listening; empathy, respect and need for speech synchrony, essential approaches to communicating difficult news. In this perspective, the importance of training is understood from the contact with reality, with the experience of daily health care, specifically in the process of palliation of the patient and family, which is essential for the communication of bad news.

The professional experience factor is never enough in situations of fragility, since the bond with the patient and his/her family influences the professional's emotional balance to provide communication and assistance. Clinical simulation is a strategic training tool for health education. There are other teaching strategies for communicating critical situations, such as brochures, audiovisual materials, counseling and interactive websites to qualify the dialogue and encourage participation in decision making. It is observed that all education for involvement in the guiding and communication is more focused on the patient than on the patient-family binomial.[9]

Education and curriculum development need to explore the perspectives of patients and families and ways of approach by health professionals. In this conception, it is understood that communication between the interdisciplinary team, family and patient is crucial to promote quality and safety in the development and planning of assistance to patients in palliative care. The failure in communication in this scenario has contributed to the low adherence to palliative care, as well as the occurrence of adverse events and, consequently, the decrease in the quality of care.[4,22]

In the course of the simulation activity, the skills which have potential in training through the use of this strategy meet the principles of palliative care, involve sensitive verbalization, empathy, approximation and, above all, active and attentive listening. That which is interpersonal needs to respect the limits of each being. To do so, reporting difficult messages requires understanding when, what and whether or not to listen to the other.[23]

Clinical simulation allows students to develop knowledge, skills and attitudes that better prepare them to deal with the patient and their family, making it possible to conduct clinical reasoning and care in an ethical and safe way.[24] Furthermore, the simulation favors not only the development of competencies corresponding to clinical processes of professional practice, it goes beyond technical and technological aspects and extends to the development of analysis, synthesis and decision making.

The post-action review and reflection in the simulation activity happens as the final stage of the teaching-learning process. It presents immediate feedback and follows a systematic formative assessment. In the expression of the students, clinical simulation in communicating bad news was a time to learn from experience, to observe potentialities and weaknesses in decision making; and the importance of the patient/family/professional relationship in attentive and respectful care at this stage of existence. Clinical simulation for the exercise of activities by health professionals is essential, given that it favors learning and performance qualification based on the assessment of the accomplished, multi-professional sharing of knowledge. Training in communicating difficult news for Nursing favors quality assistance to patients and families, in the technical, emotional, social and human scope of the living process of all palliative therapy.

This research aims to contribute to the training process of nursing students, showing that clinical simulation, as a tool in the teaching and learning process, enables the development of competencies (knowledge, skill and attitude) that better prepare students for practice, and which transcends academic knowledge, characterized by the need to know how to communicate, carry out clinical reasoning and decision-making, prepares them to face their own fears. It also contributes to a more qualified and sensitive care to the needs of people and families in critical situations of palliative care

CONCLUSION

When identifying the perception of nursing students regarding the communication of critical situations in palliative care, it was observed that there is difficulty in managing communication with the patient and their family, and that there is a need to create strategies that can help them in the process of care and facing their own fears. Bearing in mind that the data show their little experience in this activity, as well as the difficulties encountered, stand out feelings of: denial, anger and guilt. As for the difficulties, there were the fear of talking to the family and the way of speaking, in addition to the insecurity of going through this reality.

As for the skills and competencies improved through realistic simulation, the following stand out: development of active listening, empathy and non-verbal communication. In this sense, it is emphasized that the students had the opportunity to improve the necessary skills for dialogue with the patient and their family, intensify the importance of creating and maintaining spaces for clinical simulation with actors to figure the reality of nursing practice and the humanized and qualified assistance.

Thus, it is pointed out that continuous learning through active methodologies and approximation to reality in the use of protocols, clinical simulations and dialogue about the process of death and dying is essential to qualify the communication of difficult news. Understanding your own feelings regarding health care in the context of critical situations is challenging in the daily practice of clinical nursing. It is important to clarify that the clinical practice of these students, in the field of nursing, is still incipient and they need skills to communicate information that requires subtlety and delicacy to be addressed.

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AUTHORS' CONTRIBUTIONS

Substantial intellectual contribution to the conception or design of the study / research, the acquisition, analysis or interpretation of the data. Approval of the final version of the content to be published. Agrees to take responsibility for all aspects of the work ensuring the accuracy or integrity of any parts of the work: Maria Lígia dos Reis Bellaguarda

Substantial intellectual contribution to data acquisition, analysis or interpretation. Approval of the final version of the content to be published. Agrees to take responsibility for all aspects of the work ensuring the accuracy or integrity of any parts of the work: Adriana Dutra Tholl. Gustavo da Cunha Teixeira

Substantial intellectual contribution to data analysis or interpretation. Approval of the final version of the content to be published. Agrees to take responsibility for all aspects of the work ensuring the accuracy or integrity of any parts of the work: Neide Da Silva Knihs. Bruna Pedroso Canever. Ana Graziela Alvarez

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REFERENCES

1. Nogueira JWS, Rodrigues MCS. Effective communication in teamwork in health: A challenge for patient safety. Cogitare Enferm. 2015 jul/set;20(3):636-40. http://dx.doi.org/10.5380/ce.v20i3.40016
2. Bailey M. Communication failures linked to 1.744 deaths in five years, US malpractice study finds. Stat. 2016 fev 01
3. Broca PV, Ferreira MA. Communication process in the nursing teama based on the dialogue between Berlo and King. Esc Anna Nery. 2015 jul/set;19(3):467-74. http://dx.doi.org/10.5935/1414-8145.20150062
4. Araújo MAN, Lunardi Filho WD, Silveira RS, Souza JC, Barlem ELD, Teixeira SN. Patient safety in the perpective of nurses: A multi professional issue. Enferm Foco. 2017 fev;8(1):52-6. http://doi.org/10.21675/2357-707X.2017.v8.n1.984.
5. Giménez-Espert MC, Prado-Gascó VJ, Valero-Moreno S. Impact of work aspects on communication, emotional intelligence and empathy in nursing. Rev. Latino-Am. Enfermagem. 2019 fev;27:1-7. http://dx.doi.org/10.1590/1518-8345.2933.3118
6. Teixeira EHM, Queiroz ABH, Mota MSC, Carvalho MCMP, Costa EPS. Saúde da mulher na perspectiva a assistência prestada pela enfermagem ginecológica: um relato de experiência. Cad Espaço Feminino. 2013 jan;26(1):179-89.
7. Carvalho ECC. A look at the non-technical skills of nurses: Simulation contributions. Rev Latino-Am Enfermagem. 2016 dez;24: e2791. http://dx.doi.org/10.1590/1518-8345.0000.2791.
8. Oliveira SN, Prado ML do, Kempfer SS. Use of simulations in nursing education: An integrative review. REME. Rev Min Enferm. 2014;18(2):496-504. http://dx.doi.org/10.5935/1415-2762.20140036
9. Prado RT, Leite JL, Silva IR, Silva LJ, Castro EAB. The process of dying/death: Intervening conditions to the nursing care management. Rev Bras Enferm. 2018;71(4):2005-13. http://dx.doi.org/10.1590/0034-7167-2017-0173. PMid:30156690.
10. Junta de Andalucía. Fundación Progreso y Salud. [Internet]. Granada, Espanha: Consejerá de Salud; 2014 [citado 2019 maio 20]. Disponível em: https://www.linkedin.com/company/iavante-foundation
11. Silva Júnior SD, Costa FJ. Measurement and verification scales: A comparative analysis between the likert and phrase completion scales. Rev Bras Pesq Mark [Internet]. 2014 jun; [citado 2019 maio 18];15:1-16. Disponível em: https://docplayer.com.br/5969183-Mensuracao-e-escalas-de-verificacao-uma-analise-comparativa-das-escalas-de-likert-e-phrase-completion.html
12. Bardin I. Análise de conteúdo. Lisboa: Edições Setenta; 2010. 226 p.
13. Rodriguez MIF. Silenced farewell: Medical staff, family, patient – accomplices in the conspiracy of silence. Psic Rev São Paulo [Internet]. 2014 nov; [citado 2019 maio 15];23(2):261-272. Disponível em: https://revistas.pucsp.br/index.php/psicorevista/article/viewFile/22771/16503
14. Paula TRS, Borges MS, Bottini ME, Souza MCS, Ribeiro MS. Analysis of the film my life under the perspective of the kübler-ross model. Rev Enferm Cent-Oeste Min. 2017 set;7:1-11. https://doi.org/10.19175/recom.v7i0.1594
15. Freitas TLL, Souza SS, Madureira VSF, Silva TG, Maestri E, Migliorini O. Conhecendo as metodologias do ensino do processo de morte e morrer nas escolas de graduação em enfermagem no município de Chapecó/SC. Revista de Enfermagem [Internet]. 2016 [citado 2019 maio 10];12(12):37-47. Disponível em: http://revistas.fw.uri.br/index.php/revistadeenfermagem/article/view/2222/2237
16. Sampaio CL, Neri MFS, Araújo MAM, Caetano JA, Eloia SMC, Souza AMA. Problem-based learning in teaching of thanatology in

undergraduate nursing program. Esc Anna Nery. 2018 jun;22(3):1-7. http://doi.org/10.1590/2177-9465-EAN-2018-0068

17. Judd BK, Currie J, Dodds KL, Fethney J, Gordon CJ. Registered nurses psychophysiological stress and confidence during highfidelity emergency simulation: Effects on performance. Nurse Education Today. 2019 jul;78:44-49. https://doi.org/10.1016/j.nedt.2019.04.005
18. Head BA, Schapmire TJ, Earnshaw L, Chenault J, Pfeifer M, Sawning S, et al. Improving medical graduates' training in palliative care: Advancing education and practice. Adv Med Educ Pract. 2016 jul;7:99-113. http://dx.doi.org/10.2147/AMEP.S94550.
19. Mondragón-Sánchez EJ, Cordero EAT, Espinoza MLM, Landeros-Olvera EA. A comparison of the level of fear of death among students and nursing professionals in Mexico. Rev Latino-Am Enfermagem. 2015 mar/apr;23(2):323-28. https://dx.doi.org/10.1590/0104-1169.3550.2558
20. Karadag E, Kilic SP, Ugur O, Akyol MA. Attitudes of nurses in Turkey toward care of dying individual and the associated religious and cultural factors. J Relig Health. 2019 jun;58:303-16. https://doi.org/10.1007/s10943-018-0657-4.
21. Zhang H, Goh SHL, Wu XV, Wang W, Möreliusa E. Prelicensure nursing students' perspectives on video-assisted debriefing following high fidelity simulation: A qualitative study. Nurse Education Today. 2019 ago;78:1-7. https://doi.org/10.1016/j.nedt.2019.05.001
22. Duarte CLM., Boeck NJ. Trabalho em equipe na enfermagem e os limites e possibilidades da estratégia saúde da família. Trab Educ Saúde. 2015 set/dez;13(3):709-20.
23. Galvão A, Lopes S, Certo AB. Cuidados paliativos em contexto de formação de licenciatura em enfermagem. In: Sousa P, Paiva A, Pereira F, Filipe M, Osório C, Moreira S. ICHI 2014: Livro de resumos do Congresso Internacional de Informação em Saúde; 2014. Porto: Escola Superior de Enfermagem do Porto. p. 24.
24. Oliveira RRC, Medeiros SM, Vitor AF, Lira ALBC, Martins JCA, Araújo MS. Types and purposes of the simulation in undergraduate nursing education: integrative literature review. Revista Baiana de Enfermagem. 2016 jul/set;30(3):1-11. https://doi.org/10.18471/rbe.v30i3.16589.