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Acceptability and efficacy of a communication skills training for nursing students: Building empathy and discussing complex situations

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Abstract

Nurses must demonstrate effective communication across complex interpersonal domains, as emphasized by numerous professional healthcare organizations. However, formal communication skills training has been only modestly integrated into baccalaureate nursing programs, and of those studied systematically, there are notable methodological concerns. The current study focused on application of a well-researched communication program (Comskil) to student nurses completing summer internships at a comprehensive cancer center as part of their clinical education. The Comskil training program for student nurses is an in-person, day-long training that includes three sections: responding empathically to patients; discussing death, dying, and end-of-life goals of care; and responding to challenging family interactions. Student nurse participants provided strongly favorable perceptions of the program, with 90% indicating that they agreed or strongly agreed with all perception items. A significant pre- to post-training improvement in self-reported

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Author Statement

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Declaration of competing interest

None.

Ethical approval

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confidence was observed ($p < .01$). Additionally, pre- and post-training observational coding of standardized patient assessments indicated significant improvements in usage of the following skill categories: total skill use, information organization, and empathic communication ($p < .001$). Overall, these results suggest that communication skills training for student nurses is a feasible, acceptable, and effective way of increasing confidence and skills usage in complex clinical scenarios.

Keywords

Nursing education; Communication; Empathy; End-of-life care

According to the American Association of Colleges of Nursing, nursing program graduates are expected to demonstrate skill across a variety of complex interpersonal domains (problem solving, leadership, interprofessional collaboration, autonomy, integrity) – most notably communication, which is referenced across many of their “essentials of baccalaureate education” (American Association of Colleges of Nursing, 2008). Despite increasing emphasis within academic and research frameworks in the United States and internationally (International Council of Nurses, 2008; Sharon et al., 2019), formal communication training for nursing students has been modestly integrated into baccalaureate programs, often without systematic examination of their efficacy (Gutiérrez-Puertas et al., 2020; Windsor et al., 2012).

Poor communication is identified as a barrier to effective care across many areas of nursing (Banerjee et al., 2016; Beckstrand et al., 2012; Gillett et al., 2016) and may lead to adverse patient outcomes, including lower satisfaction, reduced adherence to treatment recommendations, and poorer health outcomes (Burgener, 2020; Charlton et al., 2008). Conversely, decreased provider anxiety and improved communication skills are linked to improved disease prevention efforts, treatment adherence, and satisfaction for patients (Charlton et al., 2008; Howick et al., 2018; Taghizadeh et al., 2018). Many student nurses express anxiety or lack of confidence in their ability to communicate with patients (Fisher, 2002; Szpak and Kameg, 2013). Students identified numerous barriers to effective communication, including reluctance to engage with patients or families, difficulty initiating or maintaining conversation, feeling devalued or inadequate, feeling frightened or anxious about engaging in advanced or complex conversations (e.g. discussing death and dying), and continuing to worry about their performance after the interaction has ended (Kav et al., 2013; Lin et al., 2017).

Numerous methods have been suggested to improve patient care through nurse education, including simulated clinical experiences (Coleman and McLaughlin, 2019), training with standardized patient interactions (Kameg et al., 2014; MacLean et al., 2017), peer instruction and mentoring (Moscaritolo, 2009), mindfulness practice (Ponte and Koppel, 2015), and communication skills training (Banerjee et al., 2017). Of these, training in communication skills is one of the most widely applied and studied, as it has begun to be integrated into pre- and post-graduate medical and nursing education (Berkhof et al., 2011; Bylund et al., 2011; Kruijver et al., 2000). Communication skills programs designed for nursing

and nursing students have focused on effectively gathering and imparting information and communicating empathically (Banerjee et al., 2017; Call, 2016). Typically, such programs involve a combination of activities, including didactics, role playing, modelling, simulated patient experiences, and recording and critique of interactions (Alhassan, 2019; Shorey et al., 2018).

However, there are some notable challenges in implementing and measuring efficacy of these programs. First, the range of topics covered is narrow [e.g. asking before telling, gathering and imparting information, clarifying goals and expectations, empathic communication (Rosenzweig et al., 2007; Zavertrnik et al., 2010)] and inconsistent across programs and learner populations. In some cases, the content of the training is not specified (Gutiérrez-Puertas et al., 2020). Few nursing programs include training on complex and highly emotional situations, such as responding to difficult patients or families, handling requests for unwarranted treatment, and discussing death and end-of-life care (Bloomfield et al., 2015; Ferrell et al., 2016), though these components frequently are featured in physician and registered nurse communication skills programs (Arnold et al., 2017; Banerjee et al., 2017; Bylund et al., 2011). A second problem in implementing nursing student communication skills training is unstandardized or idiosyncratic measurement of outcome measures (Alhassan, 2019). Numerous methods have been developed by individual institutions to assess program acceptability and efficacy, but few have been accepted across institutions or across the field (MacLean et al., 2017). Frequently, participant satisfaction with the training program and self-reported skill usage are the main outcome measures, often assessed through questionnaires developed by individual investigators or institutions (Mullan and Kothe, 2010; Rosenzweig et al., 2007), although some studies use pre-existing measures of related constructs (problem solving, motivation to learn: Yoo and Park, 2015). Additional measurement techniques used include participants' final grade in an academic course as a "quantitative" or observation measure (Mullan and Kothe, 2010) or qualitative or narrative responses to assess participants' experiences (Davies, 2016). In addition, researchers may not provide adequate psychometric data on their measures to allow for comparison across studies (MacLean et al., 2017).

Given that the goal of such training programs is to improve communication skills and behavior change, the gold standard of measurement appears to be objective evaluation of standardized patient assessments (SPAs: Bloomfield et al., 2015; Ryan et al., 2010; Schlegel et al., 2012). SPAs are structured interactions with a trained professional (often an actor) in realistic clinical scenarios. Benefits of assessing participants using this method include standardization of clinical scenarios and providing direct observation of communication skills, while drawbacks include that the interaction may seem stilted or artificial to the participants and does not provide a direct measure of patient outcomes (Gerzina and Stovsky, 2020; Kruijver et al., 2000). Numerous studies have found that SPAs are efficacious in both training and assessment of communication skills in nursing students (Bloomfield et al., 2015; Hsu et al., 2015; Ryan et al., 2010; Schlegel et al., 2012); however, this strategy has not been universally implemented in nursing programs (MacLean et al., 2017; Ross, 2012).

We sought to address these methodological concerns through tailored application of a well-studied communication skills training program (Comskil; Bylund et al., 2011) to a population of nursing students with goals of increasing confidence and efficacy in communication. To address the limited variety of topics covered in nursing communication skills training programs, we developed the program after conducting a detailed needs assessment of communication challenges for oncology nurses (Banerjee et al., 2016) and in consultation with experts in the fields of nursing and communication. To address the second critique regarding unstandardized outcome measurement, we employed self-report measures which have been consistently used for program evaluation and participant self-ratings during the Comskil research program. In addition, we utilized SPAs for role-plays, as well as pre- and post-training assessments – coupled with an empirically validated observational coding system (Banerjee et al., 2017; Bylund et al., 2011, 2017). Pilot data from this project was presented previously (Cannity et al., 2019), and this paper represented an expansion and deeper analysis of those findings.

We hypothesized that the Comskil training program for nursing students would have high levels of acceptability and result in significant increases in confidence between pre- and post-training and increased frequency of good communication skills, including empathy, questioning, agenda setting, information organization, and checking.

H1. Participants would report favorable perceptions of the communication skills training program. These perceptions would be observed overall and for each training component.

H2. Participants would report improved confidence in communicating with oncology patients from pre-to post-training. This improvement would be observed overall and for each training component.

H3. Participants would demonstrate improved communication skill usage in SPAs from pre-to post-training.

1. Methods

The research design was a single-arm pre-post study. This study received exemption by the institutional review board of the hospital (IRB #: X13-028).

2. Sample and setting

158 nursing students completing a clinical rotation at a large cancer center in the northeastern United States participated in the Comskil training as a part of their clinical education. Students attended workshops from July 2015 through June 2018, and all nursing students completing rotations at this hospital during this period were required to attend this training.

3. Methods and variables

3.1. Comskil training

Students participated in a one-day, three-topic workshop, which included didactics, role plays, video feedback, and pre- and post-SPAs. With input from senior nursing staff, this program was tailored to provide training for communication encounters previously identified as particular areas of concern for oncology nurses: responding empathically to patients; discussing death, dying, and end-of-life goals of care; and responding to challenging family interactions (Banerjee et al., 2016, 2017).

Each section began with a 30-min didactic which described the goals of the component, current literature on the skill, specific techniques for participants to use, and a short video demonstrating the techniques. Students also received a workbook with this information and additional suggestions and resources. Following this, students were divided into groups of three for breakout role-play sessions lasting approximately 90 min, which in most cases were co-facilitated by a communication specialist – an individual with an advanced degree in psychology or communication – and a nurse with significant clinical experience and training in facilitation of communication training. When possible, students were grouped based on placement settings (e.g. urgent care, intensive care, outpatient). During role plays, students completed brief interactions with trained actors simulating patients, based on vignettes developed by nursing experts. For example, during the end-of-life section, students were asked to role play a meeting with a patient to discuss her understanding of her cancer status and interest in care options such as hospice. Students then receive verbal feedback from peers, facilitators, and the actor, and they reviewed video footage of the interaction.

Program effectiveness was assessed based on the Kirkpatrick model (Kirkpatrick and Kirkpatrick, 2006), a widely used means of program evaluation (Bos–van den Hoek et al., 2019; Konopasek et al., 2017). This model recommends evaluating programs on four levels: 1) the reaction of participants to the program, 2) evaluation of the participants' learning, 3) changes in behavior based on the program, and 4) completion of the program's objectives. Because this is an efficacy study, we concentrated on the first two levels. Participants' reactions were evaluated through self-reported perceptions of the communication skills training program. These measures were administered by program assistants not directly involved in the research team. Evaluation of participant learning was assessed through self-reports of their confidence and completion of pre- and post-SPAs.

4. Measures

4.1. Perception of course effectiveness

Following completion of each component, participants were asked to rate the effectiveness and applicability of the skills taught. Items were rated on a five-point Likert scale ranging from one (*Strongly disagree*) to five (*Strongly agree*) with eight questions assessing the effectiveness of the course. Example items include “The skills I learned today will allow me to provide better patient care,” “The module prompted me to critically evaluate my own communication skills,” and “The experience of video feedback was helpful to the development of my skills.” In addition, participants were asked to rate the degree to which

specific components (didactic teaching, exemplary videos, and role plays) aided in their learning. These three items were measured on a three-point Likert scale from one (*Did not aid my learning at all*) to three (*Aided my learning a lot*).

4.2. Self-report of communication skill usage

Participants' uptake of skills was assessed through two methods: self-reported pre- and post-training confidence in the specific communication skills and through observational coding of videotaped standardized patient interactions. Self-reported confidence was assessed on a five-point Likert scale ranging from one (*Strongly disagree*) to five (*Strongly agree*). One item measured retrospective pre-training confidence in communication skill usage (*Before this module, I felt confident about this task*), and two items assessed post-training confidence (*Now that I have attended this module, I feel confident in my ability to perform this task; I feel confident that I will use the skills I learned today*).

4.3. Observational coding of communication skill usage

Additionally, participants' uptake of skills was measured through observational coding of pre- and post-training SPAs. Students completed 8-min video-recorded SPAs during which they interacted with a trained actor portraying a patient during a standardized, structured clinical scenario. These interactions were coded by two independent, trained coders – blinded as to whether the scenarios were pre- or post-training – using the Comskil coding manual developed by Bylund and colleagues Bylund and colleagues (2011).

The Comskil coding system (CCS) was developed to assess usage of a variety of effective communication strategies in medical scenarios. The coding system was created for use with physician interactions and has been adapted for use with nursing and nursing students (Banerjee et al., 2017). Verbal communication skills are operationalized into 20 discrete skills across five domains (See Table 3 for a list of the skills and domains). Nonverbal communication is not coded in this system. For example, within the Empathic Communication domain, one discrete skill is Validate. This skill is defined as the provider making an explicit statement which conveys to the patient that it is appropriate to be experiencing or feeling the way they are. These include statements such as, "I'm sorry you have been feeling so anxious," or "This is so overwhelming." See Banerjee et al. (2017) for a comprehensive explanation of the coding system.

4.4. Reliability assessment

Two research assistants were trained by the co-authors in using this coding system until they were proficient based on coding of "gold-standard" training videos. Coders were blind to whether videos were pre- or post-training. Both research assistants started with coding the same designated subset of videos (10% of the 316 standardized patient assessment videos = 32), followed by independently coding 45% of the remaining videos each. Coding for the 32 videos was checked by the second author for inter-coder agreement to assess coder drift from the CCS. Inter-coder agreement was assessed by checking coders' percentage agreement on 15-s blocks of the standardized patient interaction. We continued with coding only when the coders achieved a minimum of 70% agreement. All disagreements were

resolved by the second author. See Banerjee et al. (2017) for a comprehensive explanation of the reliability assessment process.

5. Data analysis

Participants were rated to have found the training acceptable if they indicated that they “agreed” or “strongly agreed” with questions assessing the efficacy and usefulness of each component of the program. Self-reported improvement in confidence in communication was assessed using paired-samples *t* tests. Despite using Likert-scale data, parametric tests were used for this self-report data as the data did not violate any assumptions of normality and to prevent loss of richness of data (De Winter and Dodou, 2010). Observational coding of SPAs was used to measure skill usage, with the total number of each skills used as the unit of measurement. Paired-samples *t* tests were used to assess change in skill usage from pre-to post-training. Due to the multiple comparisons required for data analysis (1 overall skill index, 5 skill categories, 20 specific skills), a Bonferroni correction was applied ($0.05/25 = 0.002$), and we utilized $p < .001$ as the threshold for statistical significance.

6. Results

87% of the sample identified as female, and 13% identified as male. The sample had an average age of 23.7 ($SD = 3.70$). 84% of the sample was white/Caucasian, 9% Latino, 4% Asian/Asian-American, 1% black/African-American, and 1% two or more races/ethnicities. Participants attending this workshop were in their final year of their bachelors nursing education.

6.1. Perception of course effectiveness

See Table 1 for frequency statistics of participant ratings of course effectiveness. Based on self-report, participants generally rated the Comskil course as highly helpful, with 90% endorsing agreement or strong agreement with the efficacy of the course overall. In addition, over 90% of participants agreed or strongly agreed that the responding empathically and discussing death, dying, and end-of-life goals of care components were useful. Further, for the challenging family interactions component, over 90% of participants reported that the skills learned were useful and prompted critical evaluation of their skills and over 85% of participants agreed or strongly agreed that the large-group role-playing format was effective for skill development. When considering each aspect of the training individually (didactic learning, exemplary video, small-group role-play, large-group role-play), more than 90% of participants reported that these techniques somewhat or strongly aided in their learning (See Table 2).

6.2. Confidence

See Table 1 for frequency statistics of participants’ self-reported confidence. Based on self-report, most participants (78%) reported that before training, they were ambivalent or not confident about their communication skills. Following training, more than 80% reported that they agreed or strongly agreed that they feel confident in their communication abilities. Within the empathy component, 66% of participants described themselves as

unsure or not confident before the training, while 90% reported that they were confident or strongly confident at using those skills after training. Similarly, before the discussing death, dying, and end-of-life goals of care component, 82% of participants reported that they were ambivalent or not confident about communicating, while after this component, 73% reported that they were confident or strongly confident in their communication skills. The challenging family interactions training showed the greatest percentage change in self-reported confidence from pre-to post-test, with 85% of participants describing themselves as unsure or not confident beforehand and 80% agreeing or strongly agreeing that they were confident in their skills following the training.

A paired-samples *t*-test indicated that overall, participants' post-training self-reported confidence in communication abilities was statistically significantly higher than before training [$t(472) = -30.12, p < .01$]. This finding held true across all components: responding empathically [$t(157) = -15.59, p < .01$], discussing death, dying, and end-of-life goals of care [$t(156) = -20.40, p < .01$], and challenging family interactions [$t(157) = -18.29, p < .01$].

6.3. Communication skill usage

See Table 3 for descriptive statistics and *t* values of participants' pre- and post-testing communication skill usage. Before the training, participants demonstrated an average of 8.28 skills per interaction (range: 1–20; SD = 3.57). Following training, participants demonstrated an average of 10.00 skills (range: 2–23; SD = 4.11), a statistically significant increase from pre-to post-training [$t(156) = -4.69; p < .001$]. Participants also demonstrated a statistically significant increase in skill usage across five of the 20 skills (review next steps, encourage expression of feelings, validate, normalize, and praise patient efforts) and across two of the five domains (information organization and empathic communication). There was not statistically significant change in the other discrete skills or overall scores in the agenda setting, checking, or questioning domains.

7. Discussion

This study demonstrated the acceptability and efficacy of a one-day training program to improve communication skills in student nurses practicing within an oncology setting. Specifically, our first hypothesis was supported, such that participants rated the overall training and all three components as highly effective, based on self-report. Participants also reported that each method of teaching skills (e.g. video examples, small-group role play) was highly effective. Our second hypothesis also was supported; participants reported improved confidence in their communication skills overall and within each training component. Finally, from pre-to post-training, participants demonstrated overall increased skill usage in SPAs, as predicted in our third hypothesis. Greater skill usage was observed within the information organization and empathic communication domains, as well as in five discrete skills (review next steps, encourage expression of feelings, validate, normalize, and praise patient efforts). However, no significant increase in skills occurred in the other three communication domains (agenda setting, checking, or questioning) or within the other specific skill categories.

This program addressed previously identified limitations of previous communication skills trainings in nursing students (Gutiérrez-Puertas et al., 2020) through inclusion of a variety of methods of teaching and feedback (didactic, video exemplars, small- and large-group role-play). We consistently receive feedback from participants about the value of using SPAs within the learning process, consistent with the emphasis on standardized patient interactions in the literature (Ryan et al., 2010). We also were able to systematically assess change in skill usage through use of the Comskil observational coding system, which provides a rigorous and generalizable format to conduct evaluation of communication skills training program (Bylund et al., 2011).

Some limitations of the current study should be noted. We employed a single-arm research design, and there was not a control condition to allow for comparison of training and assessment. This study was conducted at one cancer center in the northeast United States, which may limit generalizability to other settings and geographical areas. In addition, student nurses recruited to this site may be homogenous in some demographic factors (race/ethnicity, level of education, previous experience) when compared to other samples of students. Self-report data was used to assess participants' confidence in communication abilities, as well as for perception of course effectiveness. Though self-reported measures of confidence generally are considered to be reliable, it may be difficult to determine their validity (Stankov et al., 2015). The current study utilized self-report measurement and observational coding [assessing the first and second levels of the Kirkpatrick model of program evaluation (2006)], but this limits generalizability of the results to other settings and leaves open the question of the durability of these findings over time. Our minimum standard for inter-rater agreement for the observational coding of communication skills was somewhat low (70% or higher). While we believe that it is important to educate student nurses in communication skills at the beginning of their career – where there may be exponential growth as they gain experience – these results cannot be easily compared to those of other medical professions or even post-graduate nurses.

Given the limitations of the current study, future directions in this area of research should include completion of randomized controlled trials to evaluate the efficacy of this training program compared to the typical nursing education. However, it is notable that there is not a clear standard, given the wide variability in the types and methods of communication skills training programs for student nurses (Gutiérrez--Puertas et al., 2020). Notably, this research was conducted at a cancer center, and the sample was made up of student nurses completing clinical rotations within this hospital. Further, some examples and prompts used within Comskil training and SPAs are related to cancer. This leaves open the question of whether these results are applicable to student nurses working in other settings or with other patient populations. Studies in other settings suggest that good communication, trust in one's provider, empathy, and willingness to address difficult topics may be just as important as in oncology settings (Curtis et al., 2013; Dwamena et al., 2012). In addition, nursing students completing rotations in a cancer center likely will take jobs across settings after they graduate, taking their communication skills training with them. The applicability of oncology-based communication skills training for nursing students and nurses in other settings is an important area for future research.

It also would be important to assess long-term maintenance and growth in communication abilities following the training. This is vital because very few studies assess the durability of communication skills training (e.g. Webster, 2014) despite the necessity of these skills across the career lifespan of nurses (Banerjee et al., 2017). The current study evaluated the acceptability and efficacy of this training program using the first two levels of Kirkpatrick and Kirkpatrick's (2006) triangle of program development. Future research also should focus on levels three and four – evaluating generalization to real-world clinical practice and whether the training program influences patient outcomes. Further, it would be beneficial to evaluate how communication skills training affects personal factors for providers, such as empathy and burnout (Moore et al., 2018).

8. Implications for nursing

While the importance of communication skills is emphasized in both nursing education and nursing practice guidelines, (Jenerette and Mayer, 2016; American Association of Colleges of Nursing, 2008), standardized, implementable training to facilitate such skills has only recently begun to be researched systematically (Banerjee et al., 2017; Rosenzweig et al., 2007; Zavertnik et al., 2010). There were notable similarities in communication skill uptake among student nurses when compared to practicing nurses receiving similar training (Banerjee et al., 2017). Both student nurses and practicing nurses demonstrated significantly increased use of skills overall and within the empathic communication domain. Only student nurses showed significant increases in the information organization category and the clarify and validate skills, while only practicing nurses demonstrated a significant increase in the acknowledge skill. Notably, across nearly all communication domains and discrete skills, student nurses showed greater amounts of skill use during post-training standardized patient assessments. It may be that nursing students are more used to receiving and integrating instruction into their practice, as they still are in training and may have more changeable patterns of communication with patients. Alternatively, practicing nurses may have evolved more parsimonious methods of communication through their experience – requiring fewer comments to maintain high levels of effective communication.

However, it also is important to note that research shows nurses' and nursing students' level of empathy for their patients decreases the longer they work (Ferri et al., 2015; Ward et al., 2012). It should not be assumed that experience in nursing necessarily equates to effective patient communication, given the notable institutional and individual barriers nurses report (Beckstrand et al., 2012), as well as their expressed need for communication skills training in challenging aspects of patient interactions (Banerjee et al., 2016). Further, numerous studies have highlighted the beneficial aspects of effective communication for both patient and provider outcomes (Charlton et al., 2008; McCabe and Timmins, 2013). Communication skills training such as Comskil can be an important tool in maintaining empathy and effective patient care across the nursing career span. (Kruijver et al., 2000; Ward, 2016).

9. Conclusion

Our study has demonstrated the applicability and initial efficacy of a communication skills training program for student nurses. Given the significant communication challenges this population faces (Kav et al., 2013), as well as the lack of standardized methods to conduct research on these programs, we demonstrated how an existing communication skills training program (Banerjee et al., 2017) may provide high quality instruction and practice across several complex communication domains. Our hope is that well-researched communication skills training programs can be applied on a large scale to nursing education programs for the benefit of student nurses and their current and future patients.

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Table 1

Participant ratings of course effectiveness and confidence by module.

Item from Program Evaluation	Agree or Strongly Agree			
	N (%)			
	Module 1	Module 2	Module 3	Overall
Before this module, I felt confident about this task.	54 (34.1%)	29 (18.4%)	24 (15.2%)	22.6%
Now that I have attended this module, I feel confident in my ability to perform this task.	145 (91.8%)	116 (73.4%)	126 (79.8%)	81.7%
I feel confident that I will use the skills I learned today.	154 (97.4%)	152 (96.2%)	146 (92.4%)	95.3%
The skills I learned today will allow me to provide better patient care.	154 (97.5%)	153 (96.9%)	146 (92.4%)	95.6%
The module/workshop prompted me to critically evaluate my own communication skills.	155 (98.1%)	153 (96.8%)	146 (92.4%)	95.8%
The experience of video feedback/large group role play was helpful to the development of my skills.	142 (89.8%)	142 (89.9%)	137 (86.7%)	88.8%
The skills I learned were reinforced through the feedback I received in the small group.	152 (96.2%)	152 (96.2%)	N/A	96.2%
The small group/fishbowl facilitators were effective.	157 (99.3%)	153 (96.9%)	139 (88.0%)	94.7%

Note: Module 1 = responding empathically to patients; Module 2 = discussing death, dying, and end-of-life goals of care; Module 3 = responding to challenging interactions with families. Overall scores represent mean percentage across modules.

Table 2

Participant ratings of course effectiveness by component.

<u>Item from Program Evaluation</u>	<u>Somewhat Aided My Learning or Aided My Learning a Lot N (%)</u>			
	Module 1	Module 2	Module 3	Overall
Didactic teaching	149 (94.3%)	162 (96.2%)	147 (93.1%)	94.5%
Exemplary video	163 (96.9%)	152 (96.2%)	158 (93.7%)	95.6%
Role play/fishbowl experience	156 (98.7%)	154 (97.4%)	156 (98.7%)	98.3%

Note: Module 1 = responding empathically to patients; Module 2 = discussing death, dying, and end-of-life goals of care; Module 3 = responding to challenging interactions with families. Overall scores represent mean percentage across modules.

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Table 3

Student nurses' pre- and post-training skills usage results.

Skills	Pre-Training M (SD)	Post-Training M (SD)	t(df= 156)
Agenda setting	0.07 (.28)	0.14 (.37)	- 2.14 *
Declare agenda	0.05 (.21)	0.1 (.31)	- 2.72 **
Invite agenda	0.01 (.08)	0.03 (.16)	-1.35
Negotiate agenda	0.01 (.08)	0 (.00)	1.00
Take stock	0.01 (.16)	0.01 (.08)	0.45
Checking	0.32 (.70)	0.42 (.75)	-1.16
Check understanding	0.26 (.58)	0.24 (.51)	- 0.76
Check preference	0.06 (.33)	0.10 (.45)	-1.02
Questioning	5.09 (2.48)	4.74 (2.31)	1.81
Ask open questions	3.62 (2.03)	3.33 (1.90)	2.17 *
Clarify	0.15 (.41)	0.27 (.57)	- 1.70 ^
Restate	0.07 (.30)	0.14 (.37)	- 1.78 ^
Endorse question asking	0.19 (.46)	0.23 (.56)	- 0.46
Invite questions	0.9 (1.14)	0.73 (.87)	1.67
Information organization	0.33 (.53)	0.56 (.63)	-4.07 ***
Preview	0 (.00)	0.01 (.08)	-1.00
Summarize	0.01 (.08)	0.01 (.11)	- 0.58
Transition	0 (.00)	0.01 (.11)	-1.42
Review next steps	0.3 (.51)	0.51 (.55)	- 3.88 ***
Empathic communication	2.47 (2.34)	4.10 (3.05)	-6.47 ***
Encourage expression of feelings	0.58 (.90)	0.90 (.93)	- 4.08 ***
Acknowledge	0.57 (.93)	0.80 (1.09)	- 3.10 **
Validate	1.05 (1.35)	1.57 (1.45)	- 4.06 ***
Normalize	0.14 (.44)	0.34 (.62)	- 4.02 ***
Praise patient efforts	0.15 (.44)	0.30 (.66)	- 3.52 ***
All skills	8.28 (3.57)	10.00 (4.10)	-4.69 ***

^
p .10*
p .05**
p .01***
p .001.