Title: A Systematic Scoping Review and Textual Narrative Synthesis of Undergraduate Paediatric Nursing Simulations: What, Why and How?

ABSTRACT

Background: Simulation is increasingly being used to train healthcare professionals however there is limited knowledge on how paediatric simulation is being used to train undergraduate nurses. This paper systematically scopes the literature on the types of undergraduate paediatric nursing simulations taking place, their value, the research methods used and areas of research focused on.

Methods: A systematic scoping literature review, combined descriptive synthesis, and textual narrative synthesis was undertaken.

Results: 139 papers were identified by the search strategy. Of these, 32 papers were included for appraisal and synthesis. 17 papers were quantitative, five qualitative, and eight mixed-methods. The research took place in six different geographical locations. The total participant sample was 2,039. Papers were categorised according to their aims and objectives, and simulation types.

Conclusions: This review revealed the heterogeneity of studies on this subject. Ultimately, studies were small and confined to single institutions or geographical locations. Studies that described or explored simulation as an intervention provided more interesting insights than those that evaluated or tested effectiveness. The variety of simulation types was wide and the fidelity of the simulations being described was frequently noted, however no reference was made as to how this was determined. Future studies would benefit from detailing the low, medium or high technological, psychological or environmental aspects of simulation.
Key Points:

- A systematic scoping literature review, and textual narrative synthesis was undertaken to explore the types of undergraduate paediatric nursing simulations taking place, their value, the research methods used and areas of research focused on.
- A total of 32 papers were included for appraisal and synthesis. Of these 17 papers were quantitative, five qualitative, and eight mixed-methods. The research took place in six different geographical locations. The total participant sample was 2,039.
- The studies that were included were heterogeneous, often small and confined to single institutions or geographical locations. Studies that described or explored simulation as an intervention provided more interesting insights than those that evaluated or tested effectiveness.

**Key words:** paediatric nursing, baccalaureate nursing, children’s nursing, undergraduate, preregistration, simulation, scoping review, systematic review, textual narrative synthesis
INTRODUCTION
Simulation is increasingly being used to train healthcare professionals. However, there are a range of simulation types used, clinical areas of focus, and levels of fidelity described. Additionally, the research methodologies used to address simulation-based research questions are highly varied revealing the complexities of this pedagogical tool. There is limited knowledge on how simulation is used specifically to train undergraduate nurses in paediatric care. Therefore, this review aims to gain a better understanding of what types of paediatric nursing undergraduate simulation are taking place and what questions are being asked by the research in question. As far as we are aware, this is the first review of this type to be undertaken.

BACKGROUND
Simulation is a way of replicating real-world scenarios for educational and preparedness requirements (Jeffries, 2020). It is used across many sectors such as the military, aviation, and aerospace (Naseer, Eldabi, & Jahangirian, 2009). It is increasingly being used in healthcare to train undergraduate students and postgraduate professionals, however its use and evidence-base is still developing and further insight is needed to understand the fundamental nature of simulation, its uses and effectiveness as a pedagogical tool.

Paediatrics and concomitantly paediatric nursing emerged in the 19th century as concerns over child poverty and welfare and associated infectious diseases increased, while the industrial revolution meant that children’s health became a focus due to the need for a fit and healthy workforce (Mahnke 2000). The first children’s hospital opened in Paris in 1802, with London’s Great Ormond Street (GOS) and the Children’s Hospital in Boston opening in 1852 and 1862 respectively (Mahnke 2000, Connolly 2005, Clarke 2017); many more children’s’ hospitals followed in cities across the UK, USA and Europe.

In the 20th century research, which visually documented the detrimental effects of hospitalization on children, was highly influential (Robertson and Bowlby 1952; Robertson and Robertson 1968). This research changed policies related to the care of hospitalised children in the UK, Australia, Canada and European nations, and gave rise to a raft of reports which made wide-ranging recommendations including the need for children to be cared for by nurses (and doctors) trained specifically in the care of children (Bradley 2003).
The training of children’s nurses in the UK commenced at Great Ormond Street in 1878, predating the formal nurse training established by Florence Nightingale. The first nursing register overseen by the General Nursing Council was established in 1919, but initially children’s nursing was relegated to a supplementary part of the register. This was a reflection of debates which still exist today, namely whether children’s nursing is a generalist (pre-registration) or specialist (post-registration) qualification (Bradley 2003). Currently the USA and Australia view children’s nursing as a specialist (post-registration) area of practice, while a report from The Paediatric Nursing Associations of Europe (2010) reveal significant variation across Europe. In the UK children’s nursing remains a generic qualification, along with adult, mental health and learning disability nursing (NMC 2018a).

Historical analyses of the development of children’s nursing in the UK demonstrates how growth in the children’s nursing workforce has been in response to ‘memorable’ or ‘significant events.’ These events encompass social change, including the emergence of children’s rights following the 1989 Children Act, failures within UK child health services, notably the failures in management and communication uncovered in the enquiry into the action of nurse/serial killer Beverly Allitt, and changes in nurse education (Davis 2008, Clarke 2017). In respect of the latter, a fundamental reform to nurse education in the UK occurred in 1989. Referred to as ‘Project 2000’, this reform involved amongst other things, increasing the amount of theoretical training to 50% of a 3-year programme, adding the academic award diploma as a minimal exit award, and importantly for paediatric nursing the programmes led to registration as either an adult, children’s, mental health or learning disability nurse (Clarke 2017). Indeed, both Davis (2008) and Clarke (2017) observe how the arrival of ‘Project 2000’ secured the position of children’s nursing as a distinct (from adult nursing) field of practice.

Subsequently children’s nursing education has continued to evolve (Clarke 2017). More recently simulation in pre-registration nursing programmes has emerged as a key educational tool for skills rehearsal and can now be integrated across academic curricula, in both theory and practice settings (NMC 2018b). However, a consultation on the use of simulation undertaken by the Nursing and Midwifery Council (NMC 2018b) revealed some anxiety and reluctance amongst the profession about increasing the use of simulation in pre-registration nursing and midwifery education. Respondents to the consultation cited concerns about the availability of high level facilities, lack of readily available simulated learning tools, and the
promotion of simulated learning being driven by cost. Nevertheless, reviews of the use of simulation in undergraduate education indicate that simulation is an effective means of increasing knowledge, confidence and competence, clinical skills' acquisition and self-efficacy (Foronda et al 2013, Cant and Cooper 2017.) However, these reviews draw on a range of studies, few of which consider specifically children’s nursing undergraduate education. How simulation is used to train undergraduate nursing students in paediatric care is relatively unknown. With an increasing amount of studies appearing in this field it is important to gain a more in-depth understanding of what is happening, where, why and how.

The aim of this scoping review is to summarize and synthesize the global empirical literature in order to provide a comprehensive understanding of paediatric simulations used to train undergraduate nurses. The guiding research question is: What types of simulation are being used, what is their value, and what methodologies are being used to assess/understand their usage?

**METHODS**

Scoping review methodology was employed as the purpose of this review was to gain a deeper understanding of what literature and research existed on the topic rather than generate a single outcome of interest. Thus, the data synthesis in this context sought to generate a better understanding and overview of the subject in order to identify strengths and weaknesses that will inform future studies and identify what is required to further our understanding and knowledge in this area. Such a review can be an important step in understanding an area of interest when it is complex and has not been previously reviewed (Arksey & O'Malley, 2005).

This scoping review followed the Joanna Briggs Institute (JBI) methodology (Peters, et. al., 2017) and a protocol initially established the objectives, inclusion criteria and methods. This review has therefore taken the following steps: identification of area of interest, systematic literature search, data extraction, quality appraisal, data synthesis and presentation. The review follows a results-based convergent synthesis design meaning that qualitative, quantitative and mixed-methods studies are identified in a single search, presented, reported and analysed separately, and integrated during data summary and synthesis (Hong, Pluye, Bujold, & Wassef, 2017; Noyes et al., 2019). In addition, PRISMA and ENTREQ reporting
guidelines have been followed (Moher, Liberati, Tetzlaff, Altman, & Group, 2009; Tong, Flemming, McInnes, Oliver, & Craig, 2012).

Search strategy
A systematic search was completed in February 2020. EBSCO (including CINAHL), Scopus, Science Direct, and Cochrane databases were searched. In addition, the resulting papers were hand searched for specific references, which may have been missed. Search terms used were: Simul*, AND Prereg* (OR baccalaureate, undergraduate), AND Child* (OR Paediatric, Nurs*). Papers were searched between 2005 and 2020. The start date reflects the first framework developed for the designing, implementing and evaluating of nursing simulation (Jeffries, 2005). The selected database limiters were: academic journals, English language papers, and published from 2005 as presented in Figure 1.

Inclusion and exclusion criteria
For inclusion in this review, eligible studies were those that examined:
- undergraduate paediatric nursing simulation or general nursing students who undertook a paediatric simulation;
- paediatric simulation which utilised a multidisciplinary sample, but included undergraduate nursing students; and
- simulation that was physical (as opposed to virtual reality or mixed reality simulation) that used, equipment or instruments as props to replicate as far as possible, a clinical environment.

Papers were excluded if they:
- utilised e-learning or computer based simulation (unless physical elements were used),
- were OSCE’s, were role-play, used vignettes without the need to rehearse clinical skills associated with the vignettes, or
- utilised registered/ nurses post initial qualification (unless the study also included students).

Study Selection
The selection of papers followed a two stage process. The search returned 139 papers, duplicates were removed, leaving 76 papers. The full-text of the remaining papers were then assessed against the above inclusion/exclusion criteria. The reference lists of the remaining
papers were also manually searched. A further 43 papers were removed, the full-text of one paper was irretrievable (authors emailed but no response was received), leaving 32 papers to be included in the review and analysis (see Figure 1. PRISMA flow diagram).

Quality appraisal
Two researchers (SMW & RE) independently assessed 32 full-text papers using the Mixed Methods Appraisal Tool (MMAT), Version 2018 (Hong et al., 2018). Papers were segregated according to whether they were of quantitative (descriptive; non-randomized; randomized), qualitative or mixed-methods design and assessed using the criteria for their category within the tool.

Data extraction and synthesis
Data from the included studies were extracted by two authors (SMW & RE); the tool for charting the data was determined at the outset of the study, as per the following categories: source, location of study, study aims and objectives, research methods/design and sample information, type of simulation used, included participants and simulation time, measures of analysis, main outcomes, and quality appraisal scores and issues (see Table 1). Categories were kept broad due to methodological differences across and within studies and therefore summary measures were not possible. Studies were combined to summarise descriptive statistics of the study characteristics, followed by a textual narrative synthesis. This approach arranges disparate study types into more homogenous sub-groups which aids in the synthesising of different types of evidence. Study characteristics, context, quality, and findings are reported according to a standard format, and similarities and differences are compared across studies (Lucas, Baird, Arai, Law, & Roberts, 2007).

RESULTS
Quality appraisal results
Overall most studies met most of all of the five MMAT criteria, meaning that quality the quality of these studies was generally acceptable and that the appropriate methods were used to answer the questions being raised (Figure 2). The mixed-methods and qualitative studies had the highest quality, with the quantitative designs having a lower overall quality. Individually, the descriptive quantitative studies had shortcomings related to sampling strategy and size and therefore had a higher degree of risk of bias. None of the non-randomized quantitative studies met their target population or addressed potential
confounders in the design or analysis, for example, groups were often not comparable at baseline and a number of studies failed to outline how randomization was carried out. They also had shortcomings related to the type of measurements used to address the research question and the reporting of complete outcome data. The randomized quantitative studies generally failed to describe how they conducted the randomization, and failed to provide baseline characteristics; this significantly increased the potential for bias. The mixed-methods studies mainly failed to report their rationale for using the approach. Whereas the qualitative studies failed to report data collection methods used, and the interpretation of the results. Two studies (one qualitative and one mixed-methods) didn’t meet any of the quality criteria (Cole & Foito, 2019; Rholdon, Lemoine, & Templet, 2018), and five (three qualitative, one quantitative and one mixed-methods) met all of the quality criteria for their study type (Davies, Nathan, & Clarke, 2012; Nagelkerk et al., 2014; Searl et al., 2014; Small, Colbourne, & Murray, 2018; Wyllie & Batley, 2019).

**Combined study descriptive results**

Seventeen papers were based on quantitative research approaches (eight x descriptive; three x non-randomized; six x randomized), five employed qualitative methods, and eight employed mixed-methods. A further two produced only anecdotal evidence. The research took place in six different geographical locations with the majority taking place in the USA (19), UK (5), and South Korea (3). Two were undertaken in Australia and Canada, and one in Turkey. The combined quantitative population target sample was 3,395 with an actual sample of 1,372. The combined mixed-methods sample population was 589 with a response/participant rate of 483. There were a total of 184 participants included in the qualitative studies. Simulation time ranged from five minutes to 40 hours with the average being 20 minutes. The earliest study was published in 2009, however the majority of studies were published from 2014 onwards.

**Textual narrative synthesis results**

The included studies have been categorized according to the aims and objectives of the studies, the simulation types used, and simulation fidelity. Sub-headings within each category narrate and synthesize the studies included.
Study aims & objectives types

Effectiveness studies
The majority of studies identified through the search aimed to test the effectiveness of a simulation intervention (Arslan et al., 2018; Fitzgerald & Ward, 2019; Goldsworthy, Patterson, Dobbs, Afzal, & Deboer, 2019; Harris, 2011; Kirkpatrick et al., 2018; Kubin & Wilson, 2017; Lee, Kang, Park, & Kim, 2017; Marken, Zimmerman, Kennedy, Schremmer, & Smith, 2010; McKeon, Norris, Cardell, & Britt, 2009; Megel et al., 2012; Nagelkerk et al., 2014; Parker et al., 2011; Pauly-O’Neill & Prion, 2013; Pohl, Jarvill, Akman, & Clark, 2017; Rholdon et al., 2018; Shin & Kim, 2014; Valler-Jones, 2014). This was achieved through comparing traditional forms of pedagogical approaches to simulation-based approaches, assessing examination scores and grade changes, testing pre and post changes in levels of confidence, satisfaction, self-efficacy, knowledge, critical thinking, skills acquisition, and clinical judgement and competence. All studies showed a significant increase in effectiveness across all domains. One study (Harris, 2011) saw no difference between groups of paediatric nursing examination scores but saw a significant difference in course grades, with the intervention (simulation) group ultimately having higher grades. However, none were able to demonstrate that any positive changes were long-lasting and transferred to practice. The type and quality of the research designs used mean that the findings are not generalizable beyond the local institution where the simulations were conducted. Additionally, because many of the quantitative-based studies did not assess comparability of participants at baseline, conduct appropriate randomization of groups (where required), or address potential confounding factors, the risk of bias in the studies is high and therefore the results should be treated with caution.

Evaluative studies
Many studies evaluated the perceptions of students and their use of a range of paediatric nursing simulations (Davies et al., 2012; Gamble, 2017; Kim, Oh, Kang, & Kim, 2014; Lubbers & Rossman, 2017; Stewart, Kennedy, & Cuene-Grandidier, 2010; Victor-Chmil & Foote, 2016; Wyllie & Batley, 2019). All studies deemed the simulation intervention as favourable. The overall quality of these types of studies was good to high, however they say little beyond giving insight into participant satisfaction and acceptability of the simulation. Furthermore these studies were often prone to risk of bias.
Explorative studies
Several studies aimed to explore the value of paediatric simulations in terms of how students perceived specific types of simulations (such as immersive simulations), the impact of where the simulation was delivered (in clinical practice), whether or not the approach offered students the chance to practice particular competencies and scenarios, and to explore the students lived-experience of undertaking a paediatric simulation (Alinier et al., 2014; Cole & Foito, 2019; Osman, 2014; Pauly-O'Neill, Prion, & Nguyen, 2013; Small et al., 2018). The overall quality of the studies was very poor, however, Small et al. (2018) was of a high standard and was unusual in its focus being that of the lived experience of simulation; something that is often not considered in simulation-based research but which provided a new insight and understanding.

Descriptive studies
Three studies described a simulation intervention (Aldridge, 2017; Searl et al., 2014; Zimmermann & Alfes, 2019). Two of the studies did this using anecdotal evidence and one using a qualitative evaluative approach. Those that used anecdotal evidence described how the simulation was developed, and reported on student feedback they had recalled (Aldridge, 2017; Zimmermann & Alfes, 2019). The third qualitative study described a unique approach to simulation that blended interpersonal theory with puppets behaving as children, arguing that any medium that aims to bridge the gap between theory and practice is beneficial for learning (Searl et al., 2014). The quality of this study was deemed high and provided a unique approach to simulation as well as a unique insight.

Simulation types
Individual-based simulations
Just over half of the studies (17) used simulations that had a single-patient focus (Aldridge, 2017; Cole & Foito, 2019; Goldsworthy et al., 2019; Harris, 2011; Kim et al., 2014; Lee et al., 2017; Marken et al., 2010; McKeon et al., 2009; Megel et al., 2012; Nagelkerk et al., 2014; Osman, 2014; Parker et al., 2011; Pohl et al., 2017; Rholdon et al., 2018; Small et al., 2018; Vallet-Jones, 2014; Victor-Chmil & Foote, 2016). These studies therefore tended to focus on specific skills needed to assess and care for a sick child. Some ensured the role of the parent was included whereas the majority solely included the child.
Group-based simulations
The other half of the studies included more than one child patient and multiple students as healthcare providers (Alinier et al., 2014; Arslan et al., 2018; Davies et al., 2012; Fitzgerald & Ward, 2019; Gamble, 2017; Kirkpatrick et al., 2018; Lubbers & Rossman, 2017; Osman, 2014; Pauly-O’Neill & Prion, 2013; Searl et al., 2014; Shin & Kim, 2014; Stewart et al., 2010; Wyllie & Batley, 2019; Zimmermann & Alfes, 2019). These were usually presented as ward-based simulations, immersive simulations, or community-based simulations. They often provided a more holistic team-based approach to the care of children within a healthcare system.

Simulation fidelity
While majority of the studies included in this review noted the fidelity of the simulation, how this was assessed was often not described. Where studies did described the rationale for fidelity, it was often based on whether a high-functioning mannequin was used or not, or based on how complex the simulation was deemed to be. For example, Megel et al. (2012) compared a ‘low-fidelity learning experience (without a human patient simulator)’ with a ‘high-fidelity simulation experience (with a SimBaby Mannequin)’. Goldsworthy et al. (2019) on the other hand refers to high-fidelity as relating to the level of complexity the case presents the learner. Osman (2014) refers to ‘high-fidelity’ as an interdisciplinary simulation involving a simulated patient, while Alinier et al. (2014) suggests that fidelity is related to the level of immersion in the simulation.

DISCUSSION
The types of studies included in the search results varied widely with a range of methodologies used and clinical areas of focus. The overall sample population was small considering the number of undergraduate nurses trained globally each year. The majority of studies were conducted in the USA even though their undergraduate programme doesn’t train undergraduate paediatric nurses specifically. This is surprising when there are whole countries in Europe that do train nurses in the sub-specialties as undergraduates. It could therefore be assumed that this form of early specialization would provide more scope for studies of this sort to be conducted in these countries. The type and length of the simulations undertaken also varied greatly; this highlights the sheer variety and complexity of not only the simulations themselves but also the healthcare systems that they mirror.
The lack of studies in this area pre 2009, and the increase in reporting studies of these types since 2014 reveals an increasing interest in and use of paediatric simulations to train undergraduate nurses. This review is therefore timely and provides a much needed insight into this field of study.

The textual narrative synthesis of this review proved a useful way to describe difference in the included studies, making explicit the diversity in study designs and contexts. It also described gaps in the literature. Among other conclusions above, there is substantial scope for future research to utilise simulation as an intervention, as opposed to examining its effectiveness, furthermore, there is also a need to better explain fidelity and how it is determined. Using this method has enabled us to comment on the types of paediatric-based simulation studies being conducted, and the lack of evidence in regards to transferring these skills to practice and long-term changes to student’s knowledge. It also highlighted the different types of paediatric simulation being undertaken globally, revealing the vast number of ways simulation can be researched. In order to ensure that the research is better equipped to provide a greater understanding of paediatric nursing simulations, defining the types of simulation (design) used in paediatric undergraduate nurse training is essential. This would also allow for better comparisons amongst studies as well as replication of the simulations themselves.

The studies included in this review focused on two distinct simulation designs; individual and group based designs. Individual based approaches largely focused on the development of specific nursing skills deemed important for caring for a child, that is, discrete clinical skills, such as assessment or communication with families. Group-based approaches on the other hand focused more on the teamwork and systemic aspects of caring for multiple children alongside other healthcare professionals. Both are essential skill sets for paediatric nursing students, however each require a different range of skills and competence reflecting the differing/range of contexts of clinical practice. An individual-based approach may be more useful for those who are less skilled, and for the development of psychomotor skills, while a group-based approach may have greater benefit for those who have had more clinical experience and are moving along the novice to expert (Benner 1984) continuum, and are thus developing skills associated with greater complexity. This should be an important consideration in designing future simulations and studies.
Simulation fidelity is a complex issue that is debated globally (Massoth et al., 2019; Munshi, Lababidi, & Alyousef, 2015). Fidelity relates to the realism that a simulation creates (Smith & Roehrs, 2009). There have been many attempts to categorize what fidelity means and to generate levels from low to high. Tun, Alinier, Tang, and Kneebone (2015) argue that the notion of fidelity is manufacture driven and related purely to the equipment used rather than the design or experience. Pelletier and Kneebone (2016) state that fidelity has a different meaning for different professions. Where a high-functioning, but ultimately plastic mannequin may work well for performing certain procedures (Blood Pressure, Heart Rate, Taking bloods, etc.) it is still unable to convey important human physical conditions and emotions such as raised intercostal muscles when a patient is in pain, skin temperature and pallor. Therefore, the realism or ‘fidelity’ is dependent on the learning outcomes to be achieved and the level of healthcare at which the student has been exposed to. For example, an anesthetist in a surgical simulation may find a high functioning model extremely realistic, as most of their clinical tasks will be based on the machinery attached to the patient and not the patient themselves. However, a simulation of a child presenting to accident and emergency where a nurse has to quickly assess how unwell a child is based on little information, may rely more on the child’s behavior and responsiveness, something a mannequin would struggle to replicate but a simulated patient could do well. Ultimately, all types of simulation require a trade off on what can be achieved and what cannot in order to create a good level of fidelity. While fidelity was reported in a number of the studies reviewed, how this was determined was either unclear or varied between studies. Before a simulation is designed, the learning objectives and needs of the students/participants and research should be carefully considered, working backwards to determine what types of simulation could achieve these requirements. This also arguably highlights the need for greater theoretical engagement with the issue of fidelity more generally.

Limitations
Due to the broadness and limited studies within the field of paediatric simulation for undergraduate nurses, we were unable to generate any strong evidence on any particular components or uses of simulation in this context. However, the review has provided simulation providers and researchers with a better understanding of what is being undertaken globally, its value and what further research is needed to strengthen our understanding and advance the field.
CONCLUSION
This review revealed a high heterogeneity of studies, employing a range of existing validated questionnaires, scales and assessment techniques to test effectiveness. Evaluation studies although demonstrating methodological rigor, added little beyond outlining participant satisfaction. Those that described or explored simulations as an intervention provided more interesting insights. Notwithstanding the methodological limitations of the studies selected, a picture emerges of the what, why and how, of simulation in paediatric nursing.

The studies reviewed reveal that simulation can teach pre-registration children’s nursing students a range of skills, these skills ranging in complexity, from individual psychomotor skills to more complex team-working skills. The studies confirmed that students’ confidence in their nursing skills, their perceived level of clinical competence, clinical judgement and efficacy all improved as a consequence of simulation, students highly satisfied with simulation as a pedagogical approach to skills acquisition.

The fidelity of simulation and how assessed was often not described, and indeed as noted above, what constitutes fidelity within the context of simulation is contested. However it is evident that simulation for undergraduate pre-registration children’s nursing students was used to both replicate and immerse students in a ‘real’ experience, but how this was done was very variable with limited adequate evaluation of effectiveness of given approaches.

Simulation approaches were more or less equally divided in terms of using an individual-based simulation and those which employed more complex group/multiple patient simulations. The former provided opportunity to rehearse psychomotor and fundamental communication skills, the latter provided opportunity to rehearse a more holistic team-based approach to the care of children within a healthcare system, providing opportunities for students to appreciate the central tenet of paediatric nursing – family centred care.

What emerges from the papers reviewed is a conceptual framework for the use of simulation for clinical skills development in pre-registration children’s nursing education, whereby simple psychomotor skills (i.e. monitoring skills, medication delivery skills) and communication skills are initially taught and rehearsed through simulation, prior to consolidation through placement experience. As students’ progress these skills are placed within the context of increasingly complex scenarios. The scenarios facilitate the
development of more complex clinical decision making skills, which are rehearsed within the context of the reality of service provision, namely a multi-disciplinary approach to the care of the hospitalised child.
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Tong, A., Flemming, K., McInnes, E., Oliver, S., & Craig, J. (2012). Enhancing transparency in reporting the synthesis of qualitative research: ENTREQ. *BMC Medical Research methodology, 12*(1), 181.


Records identified through database searching (Terms: Simul*, AND Prereg* (OR baccalaureate, undergraduate), AND Child* (OR Paediatric, Nurs*). Time scope 2005 to 2020 (n = 139)

Records after duplicates removed (n = 76)

Records screened using inclusion criteria (undergraduate paediatrics’ nursing simulation, physical forms of simulation, multi-disciplinary studies, general undergraduate nursing students who undertake a specific paediatric simulation).

Exclusion criteria (Maternity, Neonatal, Paramedics, E-learning/Computer based, OSCE, Role-playing, Vignettes, registered nurses) (n = 76)

Studies included in synthesis (n = 32)
### Table 1 Data extraction providing a descriptive summary of included papers

<table>
<thead>
<tr>
<th>Reference</th>
<th>Country</th>
<th>Aims &amp; Objectives</th>
<th>Methods/design &amp; Sample information</th>
<th>Type of Simulation</th>
<th>Included participants; Simulation time</th>
<th>Measures/analysis</th>
<th>Outcomes</th>
<th>Quality Appraisal (MMAT Tool)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Aldridge (2017)</td>
<td>US</td>
<td>To describe how the characters (standardised patients) were created, how standardized patients were trained, and the importance of psychosocial care with standardized patients in a paediatric end of life simulation</td>
<td>Anecdotal evidence: Describes the roles, creation, training and logistics of managing standardised patients for a paediatric simulation</td>
<td>High fidelity simulation of a two-month-old infant, who was depicted by a high fidelity mannequin, and the infant's parents, portrayed by SPs.</td>
<td>Baccalaureate nurses</td>
<td>Anecdotal feedback</td>
<td>The SP's made the simulation more realistic and favourable to the student children's nurses</td>
<td>N/A</td>
</tr>
<tr>
<td>2. Alinier et al. (2014)</td>
<td>UK</td>
<td>To explore knowledge and perceptions of students in relation to immersive clinical simulation</td>
<td>Quantitative study: Quasi-randomized control group investigation Questionnaire Sample size: 1885 Convenience sample</td>
<td>Extracurricular immersive simulation sessions for multiprofessional groups of final year health care students</td>
<td>N = 237 students from adult/children/learning disability/mental health nursing, paramedic, radiography, physiotherapy, and pharmacy 12 student children's nurses</td>
<td>Delphi validated questionnaire assessing areas of pre-simulation experience, discipline-specific knowledge, and a post-simulation experience evaluation</td>
<td>The study shows that even limited interprofessional simulation exposure enabled students to acquire knowledge of other professions and develop a better appreciation of interprofessional learning</td>
<td>1/5</td>
</tr>
</tbody>
</table>

- **Randomization not appropriately performed**
- **Groups not comparable at baseline**
- **Outcome data not reported clearly**
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<tbody>
<tr>
<td>3. Arslan et al. (2018)</td>
<td>Turkey</td>
<td>To determine the effect of classical and simulation-based paediatric nursing training on students’ perception of self-efficacy and anxiety levels.</td>
<td>Quantitative study: Two-group, nonrandomized, and quasi-experimental study Sample size: 264 Convenience sample</td>
<td>Simulation-based paediatric nursing training session covering paediatric assessment, anthropometric measurement, vital signs, medication administration, and care practice.</td>
<td>Undergraduate nursing students Control group N = 115 Experimental group N = 132 Total N = 247 5-10 minutes per simulation</td>
<td>Data were collected using the Demographic Characteristics and Perceived Self-Efficacy about Paediatric Practice Skills for Student Form and State Trait Anxiety Scale in a two step process</td>
<td>The perceived self-efficacy levels of students in the experimental group were higher than in the control group. There was no significant difference for state anxiety average scores between the two groups</td>
<td>3/5 Not representative of the target population No complete outcome data No confounders accounted for</td>
</tr>
<tr>
<td>4. Cole et al. (2019)</td>
<td>US</td>
<td>To explore if an instructional model integrated into an end-of-life simulation for undergraduate paediatric nursing course allows students to practice caring for a child and their family while developing an understanding of the unique needs of a dying</td>
<td>Qualitative study: analysis post simulation Sample size: 216 Convenience sampling</td>
<td>Paediatric end-of-life simulation. The case begins with “report” on an unresponsive young child experiencing a sudden hypoxic-ischemic brain injury. A high fidelity junior manikin is utilized and a faculty member or student portrays the role of the parent.</td>
<td>Undergraduate nursing students N = 149 20 minute simulation</td>
<td>Debriefing session and open ended four question survey (researcher developed)</td>
<td>Several themes emerged: What to say / managing symptoms at the end of life, emotional care, practice implications.</td>
<td>0/5 Qualitative approach not described Data collection methods inadequate Findings not adequately derived from the data Interpretation and coherence of</td>
</tr>
<tr>
<td>Reference</td>
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<tr>
<td>5. Davies et al. (2012)</td>
<td>UK</td>
<td>To evaluate a complex simulated scenario with final year undergraduate children’s nursing students</td>
<td>Mixed-methods study: evaluative methodology Sample size: 41 Convenience sample</td>
<td>A four-bedded ward, with the assessment unit located downstairs, in a two-bedded high dependency unit</td>
<td>Student paediatric nurses N = 40 Time: N.S.</td>
<td>6 item Likert questionnaire Open-ended questions Post-simulation debriefing and evaluation</td>
<td>The themes that have emerged from the data collected in the three cohorts are all fundamental aspects of children and young people’s nursing practice.</td>
<td>5/5</td>
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<tr>
<td>6. Fitzgerald (2019)</td>
<td>US</td>
<td>To examine nursing students' performance in providing family-centered care and empathic communication in a paediatric simulation.</td>
<td>Mixed method study: convergent parallel design Questionnaire, participants were also debriefed with open-ended questions. Sample size: 162 Convenience sample</td>
<td>The simulation content reflected two common paediatric medical situations: asthma and fever</td>
<td>Undergraduate nursing students 89 traditional baccalaureate nursing students (BSN) and 57 nursing students N = 146 15 minute simulation</td>
<td>A modified version of The Jefferson Scale of Patient Perception of Physician Empathy (JSPPPE) was used. Descriptive comparative data and content analysis</td>
<td>The researchers compared standardized actors' assessment of student empathy to the peer assessments of student empathy. Peer ratings on the JSPPPE were significantly higher. Debriefing yielded results that give insight into demonstrating empathy, observing and understanding the situation.</td>
<td>4/5</td>
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<tr>
<td>7. Gamble (2017)</td>
<td>Australia</td>
<td>To evaluate the short and medium term impact of an extended multi-scenario simulation for 3rd year undergraduate students</td>
<td>Mixed Methods study: longitudinal study and evaluation Sample size: 28 Convenience sample</td>
<td>A simulated paediatric ward included 9 patients using medium and high-fidelity mannequins, two SP’s as patients and four as parents with various clinical needs</td>
<td>Undergraduate nursing students N = 28 3.5 h simulation ward shift</td>
<td>Likert Scale on achievement of simulation objectives, impact on confidence, team work and the effect of feedback on learning</td>
<td>Positive impacts on critical nursing concepts and psychomotor skills resulted for participants in both clinical placement and beyond into the first months of employment.</td>
<td>4/5</td>
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<td>8. Goldsworthy (2019)</td>
<td>Canada</td>
<td>To test the effects of a 16-hour simulation intervention on third-year undergraduate nursing students’ confidence and competence in the recognition and response to the rapidly deteriorating adult and paediatric patient</td>
<td>Quantitative study: Quasi-experimental pre/post study Sample size: 59 Convenience sample</td>
<td>High-fidelity cases included the following: angina/cardiac arrest, COPD/respiratory failure, post-op haemorrhage, paediatric sepsis, paediatric asthma, neonatal seizures</td>
<td>Nursing students N = 43 16 hour simulation</td>
<td>Free text comment sheet Simulation Experience Scale 3 question paper based evaluation focused on perceived impact</td>
<td>The results suggest that hybrid simulation intervention that included a total of six high-fidelity simulation cases (three paediatric and three adult) and two virtual simulation cases (paediatric asthma and adult myocardial infarction) showed statistically significant increases in clinical self-efficacy among treatment participants in all domains. Furthermore, the treatment group showed significant increases in knowledge on three of the six domains.</td>
<td>3/5 Randomization not described No blinding</td>
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<tr>
<td>9. Harris (2011)</td>
<td>US</td>
<td>To determine the effect of simulation enhanced orientation on paediatric acute care examination scores and</td>
<td>Quantitative study: Pilot randomized quasi-experimental design Sample size: 71 Convenience sample</td>
<td>Four simulations – basic care of infants, medication administration, infant HPS and child HPS. Child manikins used – SimBaby and PediaSIM</td>
<td>Baccalaureate nurses N = 71. 16 in intervention (simulation group) and 55 in control group (did not</td>
<td>RN Nursing Care of Children Content Mastery Test (2008) and course grades</td>
<td>No difference between groups of paediatric examination scores. Significant difference in course grades, with intervention (simulation) group having higher grades (p &lt; 0.001)</td>
<td>3/5 Randomization not described Groups not comparable at baseline</td>
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<td>10. Kim (2014)</td>
<td>South Korea</td>
<td>To develop a simulation-based fever management module for treating children with febrile convulsion, and to evaluate students' performance and satisfaction.</td>
<td>Quantitative study: Delphi tool designed questionnaire and evaluation questionnaire</td>
<td>Fifteen-month-old baby with febrile convulsion was based on a real febrile convulsion case that had occurred in a general hospital. The simulations were scheduled in simulation rooms in which the high-fidelity patient simulators were used.</td>
<td>Undergraduate nursing students N = 147</td>
<td>Student satisfaction was measured using the Satisfaction of Simulations Experience [SSE] scale. Debriefing data were analyzed using the Matrix Method.</td>
<td>Internal Consistency, Reliability, and Correlation Matrix of the Evaluation Checklist – Chronbachs alpha .71 to .81. Feedback from student debriefing and SSE scale - The total mean score of SSE was high at 4.48</td>
<td>4/5</td>
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<tr>
<td>11. Kirkpatrick (2018)</td>
<td>US</td>
<td>To test baccalaureate nursing (BSN) students self-efficacy in communication and leadership pre and post simulation</td>
<td>Quantitative study: Pre–post quasi-experimental design Sample size: 205 Conveni...</td>
<td>High fidelity - The two scenarios included a febrile infant with meningitis and a school age child with asthma exacerbation</td>
<td>Baccalaureate nursing students (intraprofessiona l) 88 senior-level traditional students, 34 junior-level accelerated students, and 78 junior-level traditional students N = 205</td>
<td>Six-question five-item Likert scale pre-test post-test related to APN role identification and collaboration. In addition, BSN student self-efficacy in communication and leadership was measured in a 17-question Likert-item post-test (researcher developed)</td>
<td>More than 90% of BSN students agreed that they benefited from the simulation in the areas of leadership, skill development, communication, and collaboration. In addition, a statistically significant increase (p &lt; .0001) in BSN students' reported understanding of the roles and relationships between a physician, APN-, and a BSN-prepared nurse was revealed.</td>
<td>3/5</td>
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<td>12. Kubin and Wilson (2017)</td>
<td>US</td>
<td>To examine the impact of using community volunteer children on physical assessment abilities and comfort levels.</td>
<td>Quantitative study: Quasi-randomized control group investigation Sample size: 99 Convenience sample</td>
<td>High-fidelity clinical simulation/ non-acting children</td>
<td>8 hour simulation</td>
<td>Pre and Post Paediatric Student Comfort and Worry Assessment Tool The Lasater Clinical Judgment Rubric Self-evaluation Faculty Evaluation</td>
<td>Study results indicate that having students practice paediatric assessments prior to clinical experiences can reduce stress and worry whether they practice with high-fidelity simulators or community volunteer children</td>
<td>3/5</td>
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<tr>
<td>13. Lee et al. (2017)</td>
<td>South Korea</td>
<td>To determine if knowledge, confidence, ability and satisfaction with learning differ when students are educated through simulation combined with pre-education/simulation only/ and pre-education only</td>
<td>Quantitative study: Randomized quasi-experimental design Sample size: 190 Convenience sample</td>
<td>The simulation took place in a dedicated room via a high fidelity human patient simulator. The two schools that implemented the simulation used the same scenarios, evaluation tools, and a high-fidelity simulator; SimBaby mannequin.</td>
<td>Undergraduate nursing students N = 127 20-minute simulation</td>
<td>Knowledge, confidence and ability instruments were developed by the researchers. Satisfaction was measured by a validated scale</td>
<td>Simulation merged with pre-education helped students build knowledge, confidence in performance, ability in nursing practice, and satisfaction with the learning method in the context of child health nursing practice.</td>
<td>4/5</td>
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<td>14. Lubbers et al. (2017)</td>
<td>US</td>
<td>To evaluate the use of medium fidelity simulation by measuring self confidence and satisfaction</td>
<td>Quantitative study: Quasi-experimental design Sample size: 61</td>
<td>Medium fidelity - Five simulations were utilized representing a variety of ages, diagnoses, and paediatric nursing roles. Adapted to represent</td>
<td>Undergraduate nursing students N = 61 45-minute simulation</td>
<td>Educational Practices Questionnaire, Self-Confidence in Learning Questionnaire, and</td>
<td>Students were satisfied and self-confident following their simulation experience. They also reported high levels of satisfaction with the fidelity of the simulation experience.</td>
<td>2/5</td>
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<td>15. Marken et al. (2010)</td>
<td>US</td>
<td>To design and implement a demonstration project (of which simulation was included) to teach interprofessional teams how to recognize and engage in difficult conversations with patients</td>
<td>Convenience sample; Quantitative study: Questionnaire design and evaluation Sample size: 12 Convenience sample</td>
<td>A human simulator (the child) and a standardized patient (the mother) were used to model a situation where a mother had a sick child who needed attention. Interdisciplinary teams consisting of pharmacy students and residents, student nurses, and Medical resident N = 12 Time: N.S.</td>
<td>Difficult conversations - Inter-professional Teams in Difficult Conversations Self-Assessment and the directed questions on past difficult conversations. Students' performance within simulations was assessed using a rubric completed by faculty observers. Student satisfaction with the program was evaluated by a separate survey instrument administered at the end of the session</td>
<td>A significant change occurred in the pre- and Post intervention test or each question on the Inter Professional Teams in Difficult Conversations Survey. For all items, at least 50% of students moved 1 stage higher in the matrix. When evaluating the program, students said the course was thought provoking and led to self-reflection. They found debriefing to be a positive process and the feedback allowed them to see how to better approach patient situations in the future.</td>
<td>Confounders not accounted for</td>
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<tr>
<td>16. McKeon et al. (2009)</td>
<td>US</td>
<td>To compare the effectiveness and efficiency of computer-based versus traditional</td>
<td>Quantitative study: Pre-test-post-test case study design Sample size: 65 Computer based simulation created using SimWriter and traditional Manikin based simulation. Baccalaureate nurses N = 53 completed pre and post-test.</td>
<td>Four-item decision point that tested knowledge related to Quality and Safety Education for Nurses QSEN</td>
<td>There was a significant improvement (P&lt;0.001) in the overall patient-centered care competency score for all students; no differences in</td>
<td></td>
<td>3/5</td>
<td>No sampling strategy Not representative of the target population Statistical test used not reported on</td>
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<td>17. Megel et al. (2012)</td>
<td>US</td>
<td>To determine the effect of practice with a high-fidelity infant simulator on anxiety.</td>
<td>A mixed-methods study: quasi-experimental design Sample size: 52 Convenience sample</td>
<td>Low-fidelity learning experience without a human patient simulator. High-fidelity simulation experience with SimBaby manikin.</td>
<td>Undergraduate nursing students N = 52 1-hour simulation per group</td>
<td>Pre and post State anxiety (STAI) National League for Nursing (NLN) Student Satisfaction and Self Confidence in Learning Questionnaire Semi-structured, open-ended questions to elicit perceptions of students’ comfort level Audiotaped focus group discussions</td>
<td>Pre anxiety scores were found by simulation intervention for students who practiced assessment with the manikin. Anxiety scores for both groups before and after simulation experiences in the LRC were not significantly different</td>
<td>Not representative of the target population Statistical test used not reported on</td>
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<td>18. Nagelkerk et al. (2014)</td>
<td>US</td>
<td>To determine whether staff and student Patient safety practices in a hospital-based, paediatric unit</td>
<td>Quantitative study: quasi experimental design Sample size: 212</td>
<td>The simulation for students focused on a premature 2 month old (3 weeks corrected age) infant hospitalized with respiratory syncytial virus either</td>
<td>Interdisciplinary 78 undergraduate nursing students, 37 third-year</td>
<td>The Safety Knowledge Tool, the Safety Program Satisfaction Tool, the Behaviour Observation Tool</td>
<td>Significant increases in students’ safety-related knowledge Some increase for technicians and residents. RNs knowledge remained stable.</td>
<td>4/5 Rationale for mixed-methods not described</td>
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<td>19. Osman (2014)</td>
<td>US</td>
<td>To explore the impact of simulation when delivered at a district general hospital</td>
<td>Convenience sample</td>
<td>(a) experiencing respiratory distress or (b) subjected to IV fluid running too fast.</td>
<td>medical students, 49 paediatric residents and the pilot unit staff of 48 registered nurses and nurse technicians N = 78 Time: N.S.</td>
<td>(Healthcare Performance Improvement, 2006), the METI (Medical Education Technologies Inc., 2012) Simulation Effectiveness Tool and the Safety Dashboard.</td>
<td>Overall, the simulation was rated as being most successful with helping respondents think critically, communication and decision skills</td>
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<td>20. Parker et al. (2011)</td>
<td>US</td>
<td>To examine learning outcomes (knowledge) and (skills)</td>
<td>Qualitative study Sample size: 6 Conveniencesample</td>
<td>A real-time, high-fidelity simulation session in which groups of medical and nursing students managed a simulated patient as a team, using assessment and communication skills developed in previous sessions</td>
<td>Interdisciplinary Four final-year nursing and two final-year medical students 15 minute simulation</td>
<td>Focus group post simulation</td>
<td>The programme was well received, with students finding it ‘helpful’ and ‘worthwhile’</td>
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<td>21. Pauly-O’Neil &amp; Nguyen (2013)</td>
<td>US</td>
<td>To determine if paediatric simulation settings offer the opportunity to practice the six QSEN competencies? And whether the activities available in each setting are comparable</td>
<td>Quantitative study: Observational design Sample size: 13 Convenience sample</td>
<td>Not stated</td>
<td>Undergraduate nursing students N=13 210 minutes simulation</td>
<td>Authors created Time on task/clinical observation tool to measures behaviour related to QSEN competencies</td>
<td>Students spent more time on QSEN activities in hospital than the simulation lab. In both hospital and simulation the variety of the 6 QSEN competencies did not receive significant amounts of time.</td>
<td>3/5</td>
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<td>22. Pauly-O’Neill &amp; Prion (2013)</td>
<td>US</td>
<td>To determine the overall influence of a mixed</td>
<td>Quantitative study: Evaluative pre-test Integrated simulation with clinical rotation. Each scenario contained</td>
<td>Undergraduate nursing students Pre and post Knowledge of paediatric</td>
<td>Contributions of each instructional strategy was not separated. The overall impact</td>
<td>3/5</td>
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<td>23. Pohl (2017)</td>
<td>US</td>
<td>To compare paediatric knowledge and clinical simulation performance between hospital- and community-based paediatric clinical experiences</td>
<td>Educational approach on student knowledge and self-confidence with paediatric intravenous medication administration</td>
<td>Post-test pilot design</td>
<td>N = 32</td>
<td>Of an integrated approach to bridge the theory to practice gap may have great potential</td>
<td>No sampling strategy</td>
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<td>24. Rhoddon (2018)</td>
<td>US</td>
<td>To examine the effect of simulation-based learning experiences on the acquisition and retention of knowledge, behaviour, and</td>
<td>Educational approach on student knowledge and self-confidence with paediatric intravenous medication administration</td>
<td>Convenience sample</td>
<td>40 hours worth of simulation</td>
<td>Not representative of the target population</td>
<td>Not representative of the target population</td>
<td>1/5</td>
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Rationale for mixed-methods not described |
Methods not integrated |
Inconsistencies not adequately addressed |
Quality criteria of each method not adhered to |

Statistically significant differences between mean pre-intervention/post-intervention written test scores, overall simulation performance scores, and safe sleep specific simulation scores were found. Four themes emerged: fidelity of simulation experience,
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<td>25. Searl et al. (2014)</td>
<td>Australia</td>
<td>To report on an innovative simulation technique that blends interpersonal theory with puppets</td>
<td>Convenience sample</td>
<td>standardized patients to represent the mother and the nurse were used</td>
<td>sleep practice (researcher developed)</td>
<td>simulation as a learning experience, benefits of debriefing, and new information gleaned about SUIDs.</td>
<td>adequately integrated Methods not integrated Inconsistencies not adequately addressed Quality criteria of each method not adhered to</td>
<td>5/5</td>
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<td>26. Shin (2014)</td>
<td>South Korea</td>
<td>To examine the effect of integrated paediatric nursing simulation courseware on students' critical thinking and clinical judgment</td>
<td>Qualitative study: evaluation using focus group method Sample size: 15 Convenience sample</td>
<td>Puppets behaving as children</td>
<td>Undergraduate nursing students N = 15 Time = N.S.</td>
<td>Thematic Analysis of Focus Groups</td>
<td>The study deepened insights about the educative process and led to learning impacts that suggest that puppet-based learning is a powerful medium to bridge theory and practice, bringing the importance of interpersonal theory to life for students</td>
<td>4/5</td>
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- skills of nursing students regarding safe sleep practices.
- Convenience sample
- standardised patients to represent the mother and the nurse were used
- sleep practice (researcher developed)
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<td>27. Stewart (2010)</td>
<td>UK</td>
<td>To develop, implement and evaluate an interprofessional undergraduate programme using simulation to learn clinical competencies, and communication and teamwork skills.</td>
<td>Mixed-methods study: validated evaluative questionnaire. Sample size: 85 Convenience sample</td>
<td>Six clinical scenarios were developed (bronchiolitis, croup, asthma, meningococcal septicaemia, acute gastroenteritis and heart failure)</td>
<td>Interdisciplinary Fourth-year medical and third-year nursing students N= 85 20 minute simulation max</td>
<td>Validated quant and qual responses on 32 item questionnaire Examined 4 domains – acquisition of knowledge and skills, communication and teamwork, professional identity and attitudes to shared learning</td>
<td>Scores were high on quantitative measures suggesting participants were generally positive about simulation. A number of themes also emerged related to the domains discussed in the questionnaire.</td>
<td>4/5 Rationale for mixed-methods not described</td>
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<td>28. Small (2018)</td>
<td>Canada</td>
<td>To learn about baccalaureate nursing students' lived experience of high-fidelity simulation of paediatric cardiopulmonary arrest.</td>
<td>Qualitative study: phenomenological methods Sample drawn from a group of third-year BN students Purposive sampling</td>
<td>High-fidelity simulation of paediatric cardiopulmonary arrest.</td>
<td>Baccalaureate nursing students N = 12 Time = N.S.</td>
<td>Unstructured interviews digitally recorded and transcribed</td>
<td>The students found the simulation to be a surprisingly realistic nursing experience as reflected in their perceiving the manikin as a real patient, thinking that they were saving their patient’s life, feeling like a real nurse, and feeling relief after mounting stress. It was a surprisingly valuable learning experience</td>
<td>5/5</td>
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<td>29. Valler-Jones (2014)</td>
<td>UK</td>
<td>To analyse the effectiveness of peer-led simulations</td>
<td>Mixed Methods study: observation and pre-test post-test questionnaire, open-ended questions</td>
<td>Peer-led simulations</td>
<td>Child field of practice preregistration student nurses N = 24 15 - 20 minute simulation</td>
<td>Facilitators examined performance via video-recordings. Students completed an evaluation of their perceived confidence and competence levels. Thematic analysis</td>
<td>There was 100% pass rate in the assessment of students’ clinical competence following the simulation. Thematic analysis of the evaluation highlighted the learning achieved by the students, not only of their clinical skills but also their personal development.</td>
<td>4/5</td>
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<td>30. Victor-Chmil (2016)</td>
<td>US</td>
<td>To examine students (a) being immersed in a realistic yet safe situation in which child abuse needs to be reported, (b) work together to problem solve, and (c) collaborate and communicate to effectively assess, provide care, and evaluate family dynamics in a community setting.</td>
<td>Quantitative study – evaluative post-simulation questionnaire Sample size: 129 Convenience sampling</td>
<td>Child Abuse Reporting Interprofessional Simulation-Based Experience (CAR-IBSE)</td>
<td>Interdisciplinary 55 nursing and 74 pharmacy students N = 36 (66% response rate) 20 minute simulation</td>
<td>Online survey, researcher created.</td>
<td>Overall, 86% of the responding participants felt that the quality of the CAR-IBSE was high. 84% reported that they would recommend this simulation to other students, and 77% expressed an interest in participating in more interprofessional simulation activities. Measures and statistical analysis not appropriate</td>
<td>3/5</td>
</tr>
<tr>
<td>31. Wyllie (2019)</td>
<td>UK</td>
<td>To provide a formal evaluation to</td>
<td>Qualitative study: Observation of simulation and A simulation exercise was developed in which students working in</td>
<td>Pre-registration nursing students (child branch)</td>
<td>Thematic analysis</td>
<td>The results suggest that the selection of simulation as a teaching approach to</td>
<td>5/5</td>
<td></td>
</tr>
<tr>
<td>Reference</td>
<td>Country</td>
<td>Aims &amp; Objectives</td>
<td>Methods/design &amp; Sample information</td>
<td>Type of Simulation</td>
<td>Included participants; Simulation time</td>
<td>Measures/analysis</td>
<td>Outcomes</td>
<td>Quality Appraisal (MMAT Tool)</td>
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<td>Zimmerman et al. (2019)</td>
<td>US</td>
<td>To describe the development of paediatric simulation experiences that actively incorporates the role of a parent.</td>
<td>Evaluative study / anecdotal evidence Describes the simulation designed, how it has been refined through experience and the evaluation of one class undertaking the simulation</td>
<td>Each child and parent simulation encompasses a systems assessment, an SBAR report to the nurse practitioner, medical math calculations, an embedded error in the orders, and a need for patient education.</td>
<td>Baccalaureate nurses N = 37 for the evaluation component 75-minute simulation</td>
<td>Percentages of Likert scale evaluation responses</td>
<td>Developing knowledge and skills in respect of safeguarding children does merit further exploration.</td>
<td>N/A</td>
</tr>
</tbody>
</table>
Figure 2. Quality appraisal graphs/tables