Nurses in a hospital setting spend more time with patients than any other health professionals and most nurses will provide care to dying patients (McCall, 2018). Student nurses are therefore likely to encounter death and dying from the very start of their education (Brown, 2016; Poultney et al, 2014). This issue is not specific to student nurses: the World Health Organization (2014) highlights that, worldwide, there appears to be a lack of knowledge and education in this subject area, despite the vital and increasing need.

If student nurses are to care for dying patients, they must be prepared both theoretically and practically (Henoch et al, 2017; Österlind et al, 2016). However, there is evidence that they receive minimal education about the care of dying patients (Lippe et al, 2017). Furthermore, there are no clear or definitive recommendations on how and when higher education institutions (HEIs) should provide that education.

In the current adult nursing curriculum at the University of Derby, first-year students receive little preparation about death and dying before their first clinical placement. An introduction to death and dying is provided later in the first year. In 2018, we conducted a study to evaluate first-year students’ level of preparedness for their encounters with dying patients during their first placement. We undertook a literature search to ensure that the study had the right focus and supported our analysis.

This article discusses the results of the study in the light of the literature and current guidance on end-of-life care, and explores how pre-registration nursing education could be improved in that area.
Clinical Practice

Discussion

The Independent Review of the Liverpool Care Pathway (2013) highlighted that significant changes were needed in end-of-life care, including how pre- and post-registration staff are trained. In 2015, the National Palliative and End of Life Care Partnership set six ambitions for palliative and end-of-life care. The fifth ambition is that patients can expect that “all staff are prepared to care” and that, wherever patients find themselves, “health and care staff bring empathy, skills and expertise and give [them] competent, confident and compassionate care” (National Palliative and End of Life Care Partnership, 2015). All staff should therefore be involved in, and be collectively responsible for care of patients at the end of life.

Factors such as age, previous care experience and education will influence students’ attitudes towards the care of the dying (Hagelin et al, 2016). Brown (2016) highlights that HEIs may have a disproportionate number of students with little or no experience of death and dying before the start of their education, who within weeks of starting their course, may need to support a dying patient and that patient’s relatives. According to Brown (2016), this lack of exposure may compound students’ anxiety.

Evaluation questionnaire

For our study, we approached 60 first-year student nurses in adult nursing at the University of Derby who had completed their first clinical placement; 59 of them agreed to participate. These students were all a part of the current cohort of the academic year. Participants completed an evaluation questionnaire comprising 12 questions – some closed-ended (requiring a straight ‘yes’ or ‘no’ answer), some open-ended (calling for free-text replies) and some allowing for both types of answers.

A literature review was conducted. Cleary-Holdforth and Leufer (2008) suggest that a focused search question is useful as it narrows the search and helps achieve accuracy. For this study we used the SPICE model (Booth, 2004) to search the literature and this helped us maintain focus on the research question (Box 1).

As an evaluation of current teaching and clinical experience, it did not require ethical approval, but during the analysis, it became evident that not being able to explore the emotional implications for students was a limitation of the study design. Table 1 shows participants’ responses to the closed-ended questions. Among the 59 participants:

- 46 said that the sessions they had received at university before their first clinical placement had not prepared them for the care of dying patients;
- 57 thought that drop-in support sessions during clinical placements for them to discuss the death of patients would be beneficial.

Three themes emerged from the analysis of participants’ responses:

- Lack of support and lack of time to talk after exposure to death and dying;
- Communication difficulties – not knowing what to say and/or how to act when faced with dying patients, coupled with increased anxiety when meeting bereaved relatives;
- Mentors’ reactions after a patient’s death – ‘get on and deal with it’ attitude.

Standards of care at the end of life

Death is different for every person and there is no right approach that can be applied in all situations (Beckett and Taylor, 2016). Current standards and guidance insist on shared decision-making, compassion and individualised care (Nursing and Midwifery Council, 2018; National Institute for Health and Care Excellence, 2017a; NICE, 2017b; Department of Health, 2015; Leadership Alliance for the Care of Dying People, 2014). In No Decision About Me, Without Me, the DH states that patients should be involved in, and enabled to make informed decisions about, the care they receive (DH, 2012a).

More recently, the Ambitions for Palliative and End of Life Care (National Palliative and End of Life Care Partnership, 2015) stressed that each person must be treated as an individual and a holistic approach applied to their care, including personalised care planning, involvement of relatives and carers, and bereavement support – with special consideration in cases of unexpected and traumatic death. However, Beckett and Taylor (2016) have posited that, because health services focus on saving lives, support for patients at the end of life is still neglected.

Hayes et al (2014) describe good care in the dying phase as coordinated, planned, compassionate, sensitive, and using excellent communication and assessment skills underpinned by knowledge. Responses to our questionnaire showed a lack of education on compassion, communication and general understanding of death and dying, which could compromise care.

Box 1. The SPICE model

Elements of the model as defined in our study:

- S = setting (in our study, the university)
- P = perspective (in our study, student nurses)
- I = intervention (in our study, teaching on death and dying)
- C = comparison (in our study, no teaching on death and dying)
- E = evaluation (in our study, support)

Source: Booth (2004)

Table 1. Participants’ responses to the closed-ended questions

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
<th>Question not answered</th>
</tr>
</thead>
<tbody>
<tr>
<td>Did you have previous care experience before your first clinical placement?</td>
<td>41</td>
<td>18</td>
<td>0</td>
</tr>
<tr>
<td>During your first clinical placement, were you exposed to caring for a dying patient?</td>
<td>43</td>
<td>16</td>
<td>0</td>
</tr>
<tr>
<td>Do you feel the theory received at university before your first clinical placement helped to prepare you for that experience?</td>
<td>30</td>
<td>26</td>
<td>3</td>
</tr>
<tr>
<td>Do you think the current sessions (both practical and theory) received at the university before your first clinical placement, prepared you for the care of the dying patient?</td>
<td>13</td>
<td>46</td>
<td>0</td>
</tr>
<tr>
<td>Do you feel the university should offer sessions on death and dying before the first clinical placement?</td>
<td>58</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Do you think it would be beneficial for the university to offer drop-in support sessions during clinical placements for you to discuss patient deaths?</td>
<td>57</td>
<td>0</td>
<td>2</td>
</tr>
</tbody>
</table>
on care experiences; in their study, compassion meant patients felt understood, validated and heard. The DH (2012b) defines compassion as being provided through relationships based on empathy, kindness, respect and dignity. According to Cole-King and Gilbert (2011), compassion also requires warmth and a non-judgemental approach.

A lack of education on compassion may result in first-year students being exposed to potentially stressful situations that they are not sufficiently prepared for. Grubb and Arthur (2016) comment on the significance of time in education and the practical experience of caring for a dying patient – both of which contribute to a positive attitude among student nurses to patients. Furthermore, Goodman (2015) highlights the need to consider cultural, spiritual and religious needs when caring for patients at the end of life.

Howatson-Jones (2016) claims that caring for someone who is dying may raise questions about one’s own mortality. The ability to explore such questions is a crucial element of self-care (Beckett and Taylor, 2016). Gustin and Wagner (2013) state that self-compassion training and mindfulness practice enable health professionals to reflect and gain clarity on their clinical experience.

At the University of Derby, before their first clinical placement, first-year student nurses are taught about the fundamentals of nursing care and about compassion, which is one of the ‘6Cs’ (DH, 2012b). Before the first placement, the Equality Act (2010) is thoroughly discussed and a non-judgemental approach to care is promoted. This supports compassionate and individualised care. However, equality, compassion and individualised care are not routinely taught in relation to the care of the dying, while basic cultural and spiritual beliefs are discussed but with limited depth in the current curriculum. Arguably, a greater focus on patients at the end of life would be beneficial.

The use of specialised resources could help students apply their learning to this specific area of nursing care. The End of Life Care and Human Rights: A Practitioner’s Guide (British Institute of Human Rights, 2016) for example, which features real-life scenarios, could help them apply theory to practice.

Communication skills and confidence
Poor communication can have detrimental effects on patients, as well as their relatives and friends, at a particularly difficult and important time in their lives. Barr and Dowding (2016) consider communication skills as a vital tool, but Howatson-Jones (2016) notes that communication may be difficult when confidence is lacking, and that student nurses may be aware of their own emotional reactions but lack the skills to read the reactions of others.

First-year students may witness end-of-life care discussions, assessment and planning. If they have not been exposed to advanced communication skills and have limited life experience, they may be unable to draw positive learning outcomes from these conversations. Hayes et al (2014) state that students need to be aware of non-verbal communication and listening techniques.

Participants in our study reported difficulties and anxiety when communicating with dying patients, as well as with relatives during and after the dying phase. They also felt that there was a lack of support, discussion and reflection. It could be useful to discuss a framework for effective communication – encompassing listening skills and a model for end-of-life care conversations – with students before their first placements.

Anxiety and clinical stressors
A literature review exploring the impact of patient death on staff in hospitals found that nurses were negatively affected, both in their professional and personal lives (Wilson and Kirshbaum, 2011), so one may question the effectiveness of the support they may be able to offer to students. Goodman (2015) and Brown (2016) highlight that the hospital environment increases the stress of health professionals when caring for dying patients, as time constraints and potential lack of privacy and dignity can create dilemmas or ‘stressors’.

Research suggests that student nurses have difficulty in dealing with death, experience increased anxiety when exposed to it, and feel inadequately prepared for it (Strang et al, 2014; Parry, 2011). Parry (2011) reports that students felt they lacked sufficient skills to deal with death and dying and that mentors’ attitudes and the lack of support received by students restricted their ability to talk about patients’ deaths. We found these to be common themes in participants’ responses.

Improving the curriculum
Student nurses in our study felt they received inadequate education and support to help them deal with death and dying, so how could we improve the curriculum?

Building emotional resilience
HEIs are required to train students to become compassionate and caring nurses (NMC, 2018), so a compassionate and supportive educational environment is essential. Such an environment has the potential to increase students’ resilience from the start of their course, enabling them to develop coping strategies for the distressing situations they are likely to encounter. Training and education programmes featuring resilience theory and peer support have been found to result in the development of coping strategies for dying, death and grief (Arthur et al, 2011).

Before going on clinical placements, students need to be made aware of existing support mechanisms. Compassion in Practice (DH, 2012b) uses the term ‘emotional labour’ and considers the effects of caring for sick and dying patients on staff. To build their emotional resilience, both teams and individual members of staff should be able to take time to reflect on difficult cases, share their experiences and seek peer support. From a student nurse’s perspective, reflecting with others can offer support (Howatson-Jones, 2016).

Supervisors and assessors and other support mechanisms
Holmes (2005) suggests that a relationship that is supportive and allows the exploration of feelings and thoughts can relieve anxiety. This could be adopted between supervisors and assessors, incorporating the academic role. Using these roles effectively could aid the opportunity for guided reflection from experienced practitioners. This could make students feel more comfortable when discussing their thoughts and feelings, as well as create a supportive and trusting environment for learning (Johns, 2010).

Other support options could also be used to promote a space for learning and reflective practice, such as peer support via social media, allocated action learning sets and virtual learning environments (Howatson-Jones, 2016). Learning about death and dying through simulation could help students prepare for their first clinical placement. Roberts et al (2018) have explored this with the view of improving staff’s confidence and competence in caring for dying patients. Simulation is used extensively in education (Walsh, 2011), and in this case it could be used to promote compassion and empathy.

Turner et al (2000) created workshops offered to students from a range of healthcare disciplines, which used the experience of informal carers who were caring for relatives at the end of life or had gone through bereavement. The workshops, facilitated by specialist palliative care practitioners, gave students an opportunity to develop their empathy and gain a deeper understanding.
of death and dying. The workshops offered an authentic and collaborative approach to education and team development, but they were also hugely resource intensive.

Spiral approach

From our review of the literature and students’ responses to our questionnaire, it is clear that adequate preparation and previous exposure to death and dying before the first clinical placement would have a positive effect on students’ experiences. Participants’ responses made it clear that they thought more preparation was required. We believe that a spiral approach to the curriculum (Bruner, 2009) could be used, through which students would build up their knowledge and skills from year to year, for example:

- Year 1: awareness of caring for patients at the end of life and their families;
- Year 2: stages of grief and bereavement;
- Year 3: management of patients at the end of life and their families.

This would give students preparation and time to explore this crucial area of nursing before they face potentially emotionally distressing situations. A framework defining minimum learning outcomes could be used (Taylor, 2012).

Further research

To ensure shortfalls in knowledge are addressed and students are fully prepared, further research evaluating future interventions, such as a structured teaching plan and learning outcomes, may be needed. To inform the future curriculum and prepare students appropriately, further research examining the expectations of patients and families, patient assessment, care planning, symptom control and bereavement may be beneficial. Finally, the impact of incorporating such teaching and support within the current education would need to be explored. Piloting teaching designs and the effectiveness this has on student nurses via further studies will be completed.

Our study was focused on nursing, but research investigating the experiences of other pre-registration health professionals about death and dying could be useful to establish the extent to which their education programmes need to be improved.

Conclusion

Support and education for those caring for people in the last stages of life are crucial. End-of-life care is part of a nurse’s role, so the adequate preparation of student nurses is vital to ensure patients receive high-quality care. Based on the evidence throughout, we believe this crucial subject needs to be incorporated into the education offered to first-year student nurses. MT

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