FINAL YEAR NURSING UNDERGRADUATES' UNDERSTANDINGS OF PALLIATIVE CARE: FINDINGS FROM A QUALITATIVE DESCRIPTIVE STUDY IN WALES, UK.

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ABSTRACT

In the wake of policies promoting palliative care and population ageing juxtaposed against escalating chronicity across the globe, it is important for educators and practitioners who support them in practice to establish how undergraduate nurses conceptualise palliative care. When considered against increasing evidence of disparate, even blurred concepts of palliative care, this is significant. These are tomorrow's nurses and their understandings will shape the ways in which palliative care is integrated within their own professional practices. As part of a larger qualitative study of palliative care for people with advanced dementia, final year adult field nursing undergraduates' (*n*=11*)* understandings of palliative care were explored through in-depth individual interviews. Data were subject to thematic content analysis. Findings revealed participants were cognisant of the broad scope of palliative care. Moreover, they valued and appreciated compassionate comfort care and emotional support. However, their understandings were rather superficial and focused on the imminently dying phase.

KEY WORDS

Background

Internationally, demand for palliative care is set to escalate as populations' age, life-limiting progressive illnesses proliferate and rates and mortality patterns rise and change. Accordingly, palliative care has greater prominence across the globe particularly with regard to progressive, life-limiting illnesses (World Health Organisation, 2004; O'Connor, 2012). This is reflected in national and international governments' strategic health plans and policies promoting integration and implementation of palliative care for all according to need (see, for example, Scottish Government, 2008; Australian Government, 2010).

Definitions of palliative care abound in the literature. It is described as: 'an approach that improves the quality of life of patients and their families facing the problems associated with life-threatening illness' by the World Health Organisation (2010). This frequently used, needs-based definition supports intentions for an inclusive, equitable approach to palliative care set out in numerous contemporary policy documents. Undoubtedly it challenges health professionals to look and reach beyond the population with and services for cancer. Moreover it signals the significance of and responsibility for palliative care for professionals across all care settings.

Nonetheless palliative care has become a rather contested concept. This is manifest in different thinking (O'Connor, 2008; Pastrana et al, 2008; Hui et al, 2012) on the precise meaning of palliative care. Indeed, whilst the WHO (2010) definition is frequently used, different definitions are in common use across the globe (see table 1). Moreover, international empirical findings have revealed diverse understandings of palliative care in terms of its meaning, scope and practices amongst healthcare professionals (Bertero, 2002; Hanratty et al, 2006; Mahon and McAuley, 2010; Gott

et al, 2012) and the public (Claxton-Oldfield et al, 2004; McIlfatrick et al, 2013a, 2013b). In the United Kingdom the situation has been further complicated by the contemporary policy focus on end-of-life care. Here, end-of-life care is invariably defined in accordance with the General Medical Council (2010) definition as care for those "'approaching the end of life' when they are likely to die within the next 12 months. This includes patients whose death is imminent" (p. 8).

Table 1 Concepts of palliative care (Chronological order)

Organisation	Year	Definition/ Explanation of palliative care	Origin
World Health Organisation	1990	'The active total care of patients whose disease (cancer) is no longer responsive to curative treatment. Control of pain, or other symptoms and of psychological, social and spiritual problems is paramount' (parentheses added).	Switzerland
European Association for Palliative Care	2014	Palliative care is the active, total care of the patients whose disease is not responsive to curative treatment. Control of pain, of other symptoms, and of social, psychological and spiritual problems is paramount.	Europe
World Health Organisation	2010	'An approach that improves the quality of life of patients and their families facing the problems associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual'	Switzerland
American Academy for Hospice and Palliative Medicine	2014	'To prevent and relieve suffering and to support the best possible quality of life for patients and their families, regardless of the stage of their disease or the need for other therapies. Palliative care is both a philosophy of care and an organized, highly structured system for delivering care.	North America

		Palliative care expands traditional disease-model medical treatments to include the goals of enhancing quality of life for patient and family, optimizing function, helping with decision-making and providing opportunities for personal growth. As such it can be delivered concurrently with life-prolonging care or as the main focus of care'	
Center to Advance Palliative Care	2014	'Specialised medical care for people with serious illnesses. It is focused on providing patients with relief from symptoms, pain and stress of a serious illness - whatever the diagnosis. The goal is to improve quality of life for both the patient and the family'.	North America
European Association for Palliative Care	2014	Palliative care is the active, total care of the patients whose disease is not responsive to curative treatment. Control of pain, of other symptoms, and of social, psychological and spiritual problems is paramount.	Europe
National Council for Palliative Care	2014	Palliative care is the active holistic care of patients with advanced progressive illness. Management of pain and other symptoms and provision of psychological, social and spiritual support is paramount. The goal of palliative care is achievement of the best quality of life for patients and their families. Many aspects of palliative care are also applicable earlier in the course of the illness in conjunction with other treatments	United Kingdom

In the wake of policies promoting palliative care and population ageing juxtaposed against escalating chronicity it is timely to pause for thought, identify and reflect on the ways in which palliative care is understood by those who are peripheral to the speciality. It is recognised internationally that nurses have prominent roles in palliative care (Hanratty et al, 2006; Dickinson et al, 2008; Bloomer et al, 2013).

However, very little is known about how today's non-specialist nurses conceptualise the principles and practice of palliative care and even less in respect of pre-registration nursing undergraduates. Yet, the latter is important, for students are tomorrow's nurses. Moreover, as O'Connor et al (2010) wisely cautioned, 'words incarnate the service' (p.66). Accordingly this paper reports insights into final year adult field nursing undergraduates' understandings of palliative care.

Methods

The findings presented herein arise from data generated in a larger study which sought to explore final year adult field nursing undergraduates' experiences of caring for people affected by advanced dementia which took place in 2013. Given this aim, and the apparent lack of published research on the subject matter, a descriptive qualitative approach drawing on the tradition of naturalistic inquiry and as described by Sandelowski (2000) was adopted. Consideration of students' comprehension of palliative care was an important component of this project, for understandings shape nursing practice.

A convenience sample of undergraduates (adult field) nearing degree completion (*n*=68) in a Welsh university was approached and informed of the study in person by the Programme Director. Completing undergraduates were selected for they had experienced nine placements in different clinical settings across economically diverse and geographically remote, rural and urban areas in Wales. To protect anonymity those interested in participating replied directly to the researchers. Fourteen students agreed to participate.

Individual one-to-one in-depth interviews were used to collect data. Interviews have a long history in qualitative research. Their particular advantage is the

possibility to generate rich data that confers insight into experiences, thoughts, feelings and interpretations (Murphy et al, 1998). Two experienced researchers (TW & RD) who were unknown to participants conducted the interviews in private spaces at times of participants' choice in 2013. A relaxed conversational interview style (Burgess, 1988, Davies, 1999) was adopted. However, to ensure broadly similar areas were addressed during interviews a loose interview guide informed by the literature acted as an *aide memoire.* This was adapted during data collection to incorporate emergent topics identified through preliminary data analysis. Interviews lasted between 25 and 50 minutes, were digitally recorded and yielded rich data.

Ethical approval was granted from the College's research ethics committee. Written informed consent was obtained. Participants were assured of their right to withdraw and protection of anonymity. Participants were allocated pseudonyms and all identifiers were removed. Following transcription and checking digital recordings were erased. Transcriptions were stored securely.

Thematic content analysis informed by Green and Thorogood (2004) was used and commenced from the point of data collection. Digital recordings were listened to following each interview. Interviews were fully transcribed verbatim, noting pauses and intonation. Transcriptions were read whilst simultaneously listening to recordings. This enabled the identification of transcription errors which could impact on data interpretation.

Two researchers (TW &RD) coded and analysed transcripts independently. Transcripts were repeatedly read, coded and patterns in participants' understandings sought. Once identified these were assembled into broad categories and themes

then discussed, scrutinised for similarity and duplication, refined and reduced until agreement was reached.

Trustworthiness was enhanced by drawing on measures to achieve credibility, transferability, dependability and conformability (Lincoln and Guba, 1985). Meticulous full transcription and checking of interviews and rigorous data analysis by two researchers independently contributed to credibility. Detailed descriptions of experiences aided transferability whilst an audit trail of methodological decisions ensured dependability and confirmability (table 2).

Table 2: Methodological decision trail

Research Process	Decision	Rationale
Ensuring informed consent.	Once written consent had been obtained to once more reiterate information relating to the interview, the purpose, process and outputs to participants and to offer the opportunity for questions immediately prior to the interview commencing.	To ensure the participant's decision to participate was of her own accord.
Data Collection	Digitally recorded in-depth one-to-one interviews Conversational interview style. 'Member check's' during interviews. Notes made immediately after the interviews. Personal reflexive journal maintained.	To focus on the individual, her responses and to preserve verbal communication as far and as accurately as possible. To develop a relationship and offer maximum scope for exploration and flexibility to clarify meanings and interpretations through the use of prompts, probes and reflection and to seek experiences. To seek and clarify meaning and /or interpretation of meaning. To record non-verbal communication and preserve a sense of context, e.g. background noises. As the research instrument I could not be separated from the data. For example, my professional identity could shape participants' responses.
Data	1. Digital recordings were	To become immersed in the data and facilitate

Management	transcribed by one researcher as soon as possible post interview. 2. Interjections, hesitations, pauses, intonation and any corresponding non-verbal communication derived from the interview notes were highlighted. 3. Audio-check of transcript. 4. Opportunity for participants to 'member check' transcript.	dependable analysis. To aid analysis. To check for transcription error. To contribute to credibility.
Data Analysis	1. Careful reading and re-reading of transcripts. 2. Handwritten line by line initial coding of data. 3. Two researchers analysed data and generated categories independently and then discussed. 4. Comparison of findings with recent research.	To begin to code raw data of relevance to the research aim and facilitate dependable analysis. To think about the data in different ways and open up the possibility for further and different dimensions of analysis. To contribute to credibility. To determine whether findings substantiated or refuted findings reported by other researchers.
Final report	Extended data extracts used in the presentation of findings.	To provide evidence to support the analysis.

Findings

Eleven students, all female with a mean age of 35 (range 22 – 45) years participated as two were lost to follow up and one did not attend for interview. No reasons were given for non-participation. Participants' experiences were predominantly in acute settings. Several participants had visited hospices for a day or spent time with specialist palliative care nurses. Only one participant experienced a dedicated hospice placement. This was during her final year and out of choice. Several reported personal experience of advanced progressive illnesses within their immediate families.

In the following analysis participants' understandings of palliative care are reported. Two core themes emerged from data analysis: the boundaries and the practice of palliative care (Table 3).

Table 3: Students understandings of palliative care: themes, sub-themes, categories

Theme	Sub themes	Categories
Boundaries of palliative care	Inclusive approach	- Needs led - Family focus
	Temporal dimensions	- Diagnosis of progressive life limiting illness - End stage - End of life
The Practice of Palliative care	Toward a good death ideal:	- Comfort care - Symptom control - Effective communication
	Underpinning core values	- Compassionate - Person and family centred

'A fine line': The boundaries of palliative care

Participants were quite unequivocal in perceiving palliative care as an inclusive approach to care for people with illnesses where cure was not possible and prognosis poor. Indeed, only one participant perceived palliative care as a distinct, specialist service. The significance of including and supporting families threaded through most participants' accounts:

> *Supporting their* [patient's] *family which is **extremely** important.* (Karen, emphasis original, parentheses added)

> *You're just not treating the patient that you've gotta look after the family as well.* (Jill)

Yet curiously only one participant spoke of palliative care continuing into bereavement.

In terms of the broad scope of palliative care, participants' accounts displayed unified comprehension with regard to inclusivity. Yet for most this was a new understanding. Indeed, many participants articulated that they initially conflated palliative care purely with cancer. For some this connection was related to personal experiences of advanced cancer within their immediate families and social networks. However, educational preparation in palliative care also contributed:

> *We've looked at palliative care: it's as if it's looked at for patients with cancer.* (Amanda)

> *We've had a palliative care module (…). Cancer we've had a lot more lectures on it (…). We've had different services involved with patients with cancer. We've been taught about* (names hospice). *We've been taught about how to treat a patient with cancer: their wishes do they want to die at home do they want to die in hospital?* (Wendy, parentheses added)

Moreover, placement learning had exposed them to palliative care service organisation and delivery which, in their view, was entirely cancer focused:

> *You've got* (names hospice) *there haven't you specifically aimed at cancer patients isn't it for their care, for their families.* (Jill)

> *Palliative care is seen for patients with cancer. You go to a palliative ward in* [names hospital] *(…) a palliative ward for **cancer** patients. (…) it's all cancer.* (Heather, emphasis original, parentheses added)

Nonetheless, during the course of their education journey interactive, reflective pedagogical approaches had equipped participants with confidence and high order cognitive skills, notably the ability to think critically and apply sound clinical judgement in practice. This was richly encapsulated by Rebecca as her words reveal:

> *It* [nurse education] *has made me think about how I talk to people (…). Talking, doing things like sociology seminars where you end up having big debates and bashing out feelings, your feelings about things I think that's given me a lot more confidence to think about where I stand on things and be confident in my own opinions and my own knowledge of palliative care and end-of-life issues.* (Rebecca, parentheses added)

Simultaneously entwined with positive placement learning experiences, specifically the acquisition of practice knowledge and core professional values, the education process had effectively challenged and transformed participants' initial ideas about the broad scope of palliative care at least.

Despite this apparent unity in terms of understanding the broad scope of palliative care, heterogeneity was apparent in participants' accounts of the point in the illness trajectory at which palliative care began. Indeed, in terms of initiating palliative care, temporal boundaries were apparent.

Just two participants spoke of the continuum of palliative care from the point of diagnosis:

> *Palliative care let me think, which way would I word it. It's being diagnosed with a life ending illness and you're giving them the care that they need to get through.* (Jill)

> *It's* [palliative care] *not always end-of-life cos you could be palliative for years (…) you can be palliative for 10 years.* (Alicia, parentheses added)

Alicia's words quite categorically reveal her understanding of difference between palliative and end-of-life care. Yet Alicia explained this was a new understanding following an oncology placement and associated contact with the specialist palliative care team:

> *I always had the impression you're dying you're palliative but it's not and I've only learnt that since I've been with cancer patients because you know we've got the palliative care team.* (Alicia)

Most participants articulated that palliative care was synonymous with care toward the very end-of-life, often referred to as the 'end stages':

> *Palliative care is when somebody is at, quite close to, the end stages of their disease.* (Amanda)

> **I: What's your understanding of palliative care?**

> *Jessica: To, to aid people in the end stages of life.*

> *I: What's your understanding of palliative care?*

> *Rebecca: Really making things comfortable in the end stages of somebody's life.*

Typically the end stages were exemplified as a short period of time in the illness trajectory: weeks and days preceding a person's death. Interestingly, some participants posited a definite time-bounded distinction between the 'end stages' and the end-of-life. Indeed, the latter indicated a brief space in time when death was considered imminent. Moreover, in terms of care practice this signalled a change in gear and implementation of the All Wales Integrated Care Priorities for the Last Days of Life (AWICP) (NHS Wales, 2013) commonly referred to by participants as either the 'end-of-life pathway' or the 'ICP'.

'Ensuring people have the best death': The practice of palliative care

For most participants the ultimate aim of palliative care practice was the accomplishment of a good death. A defining attribute of participants' good death construct was dying well, that is to say peacefully, with dignity and in a place of the person's choosing. To realise peaceful, dignified closure on life's journey, participants articulated ensuring physical and psychological comfort toward the very end-of-life as the prime objective of palliative care practice. Comfort was achieved through symptom control conjoined with excellent communication and underpinned by compassionate, relationship-centred care.

In communicating their understanding of palliative care practice participants privileged symptom control:

> *Managing a condition that can't be cured um keeping symptoms and such like in check.* (Karen)

Making things comfortable in the end stages of somebody's life and not really, it's more symptom control than doing anything to try and reverse anything or prolong life. (Rebecca)

Inadequate symptom control was perceived as the epitome of a bad death for it compounded suffering, rendered people devoid of dignity and traumatised those bearing witness to another's suffering, families, staff and students themselves:

It can be quite distressing for their families to see them um you know when the prognosis isn't great and they are already suffering. (Jessica)

For me to see all that blood pumping out, him sort of fitting and stuff I didn't think, feel prepared at all, for dealing with death I found that death quite hard to deal with. (Alicia)

Mindful of the lasting effect of a bad death experience on the bereaved, participants were particularly attuned to ensuring pain control at the very end-of-life:

To end, pass away as pain free as possible (….). Making sure that that person isn't in pain, a nice and controlled situation. (….) I think controlled is a good word because you don't want that patient's relatives, that's the last memory they're ever going to have so you don't want that, their relatives to see them, their loved one, their husband, their wife, their brother, sister pass away … in pain. (Wendy)

Yet, several participants acknowledged the importance of preventing and easing anxiety and emotional distress. Here, effective communication was imperative:

Communication definitely that's a priority. Communication with patient but definitely the family because they, they're heartbroken, heartbroken. (Rachel)

A number of participants described how through sharing information, spending time with and listening to patients and families, relationships were forged and emotional support offered. Nonetheless, most participants articulated that in acute settings in striving to adeptly negotiate and balance the demands and constraints of temporally complex organizations against the sometimes unpredictable needs of patients, communicating with dying patients and families was time limited. Indeed, this is richly encapsulated in the following data extract:

14

They may not have time because they've got iv's to draw up or drugs to give, phone keeps ringing, they've got people to go to theatre, they've got different things going on (…). There's so much to do on the ward (…). You have a ward round that can take up to an hour sometimes and then you've got drugs to do, you've got washing and dressing, you've got to do breakfasts there's so much paper work it's unreal I mean I didn't understand how much paper work there was I can spend half my day doing paper work. (Wendy)

However some participants described how in going about their work they personally adapted their practices to engage and thus connect with patients and families, thereby demonstrating a humane, compassionate approach.

Many participants revealed that dying well and accomplishment of the good death was underpinned by the ethos and practice of compassionate care:

You've got to have a sense of compassion, definitely. (Rachel)

You have to be compassionate (…) if you're not compassionate they pick that up. (Mary)

Indeed, the significance of compassionate care was exemplified throughout participants' accounts. Dimensions of compassionate care identified included recognising vulnerability, identifying and easing suffering, protecting and preserving dignity and facilitating choice:

They need be treated with respect and dignity that you'd expect to be treated if you was in the same situation. (Alicia)

Allowing somebody to basically die where they wanna die, spend, do whatever they want to do in the last few weeks or days or moments of their life. (Heather)

Moreover, an empathic person-centred approach, which extended out to family members was perceived as being pivotal to the provision of compassionate care.

You've got to be able to just take a step back and just think 'oh what they must be going through'. (Rachel)

Being able to sympathise, empathise um being kind, understanding um I always try and put myself in their position you know focus on the person not necessarily the condition. (Anna)

15

Discussion

The interview data from this exploratory, qualitative descriptive study captured understandings of palliative care amongst a group of adult field nursing undergraduates on the cusp of their professional registration. The rich data revealed that participants were cognisant of the broad scope of palliative care and privileged compassionate comfort care and emotional support. Yet their understandings were rather superficial and focused on the imminently dying phase. To some extent this conception is reflected in their alignment of palliative care practice with a particular good death ideal.

Participants' recognised palliative care as being relevant for all those affected by progressive life-limiting illnesses, including family members. This understanding is heartening given empirical findings from across the globe continue to highlight the unmet palliative care needs of patients and families affected by a range of life-limiting conditions, not only advanced cancer (see, for example, Fitzsimmons et al, 2007; White et al, 2011; Crawford et al, 2012). Moreover, it is consistent with the World Health Organisation's vision, international governments' policy directives for palliative care and aligns with Johnston's (1999) definition of palliative nursing. Yet participants' understanding of the broad scope of palliative care was juxtaposed against ambiguity regarding the point at which palliative care begins.

Many participants were of the view that palliative care equates with care toward the very end-of-life. This was unanticipated but is perhaps of little surprise given varied discourse surrounding palliative and end-of-life care in academia, practice and policy. Participants' understandings certainly resonate with findings from national and international studies (Bertero, 2002; Hanratty et al, 2006; Mahon and

McAuley 2010; Gott et al, 2012.). Interestingly, a recent European survey (Gysels et al, 2013) revealed that professionals' understandings of end-of-life care were informed by definitions of palliative care from the World Health Organisation, policy and national associations.

In the study reported here it was clear that participants understood palliative care practice in terms of ensuring compassionate comfort care toward the very end-of-life. Moreover, they articulated the significance of effective, supportive communication with patients and families at this stage of the life-cycle. Given the significance of relationship building in palliative care (Walshe and Luker, 2010) this is indeed welcoming. Yet at the same time this is a rather narrow understanding of palliative care practice *per se,* for while palliative care is imperative at the end-of-life it is not limited to this phase.

The need to enhance care for this population is recognised globally following successive reports of sub-optimal care of the imminently dying and their families, particularly in acute care (see, for example, Rogers et al, 2000; Teno et al, 2004; National Confidential Enquiry into Patient Outcomes and Death, 2009; Le and Watt, 2010; Office for National Statistics, 2012; Gott et al, 2013). Arguably there is a sense in which the findings from this study are positive for they illuminate that tomorrow's nurses really do appreciate and are sensitive to the significance of good care underpinned by core professional values. Given evidence of disturbing aspects of nursing practice conveyed in the Mid Staffordshire NHS Foundation Trust Public Enquiry (2013) and the Clwyd-Hart (2013) reports in the United Kingdom, there is a sense in which this is welcoming.

Although the findings from the study reported here are indicative of a particular 'dying script' they do signify an aspiration amongst nursing students to promote a 'good death' experience, the achievement of which is a prominent social and political priority internationally (Ellershaw et al, 2010). In the United Kingdom, this is reflected in governments' end-of-life care strategies and reports (Department of Health, 2008; House of Commons, 2009) and, whilst recognising that it is imbued with methodological limitations, in England, the recently published Neuberger Review of the Liverpool Care Pathway (Department of Health, 2013).

That participants' understandings of the continuum and practice of palliative care were rather superficial may be an artefact of the nature and focus of their theoretical preparation in palliative care. Furthermore, their limited professional experience and minimal meaningful exposure both to people nearing the end of their lives and specialist palliative care practitioners could limit participants' opportunities for knowledge application and further development. It is of course important to note that all participants were embarking on their professional journey. Additionally, their practice learning experiences were primarily in hospital settings. In the developed world most people die in hospital settings and this is projected to increase (Gomes and Higginson, 2008; Bloomer et al, 2013). Yet, it is widely acknowledged that hospital culture is embedded in biomedicine, the science and art of cure and an ethos of task focused routine care (Tadd et al, 2011; Watts, 2012; Bloomer et al, 2013).

During their professional careers nurses are likely to care for many people with palliative care needs. Participants in this study appreciated the need for inclusive, compassionate, patient and family centred relational care. However, their tendency to associate palliative care with care of the imminently dying could set limits on their

future practice. Significantly, opportunities for optimal care of all those for whom a palliative approach might confer benefit might be restricted. Clearly this signals implications for undergraduate and post-qualification professional education and development and even specialist palliative care teams in terms of promoting palliative care principles and practice across different care settings. Indeed, this is highly significant if strategic aims of international governments for comprehensive palliative care are to be fully realised.

Without doubt much has been done internationally to incorporate palliative care into pre-registration nursing education curricula (Jacono et al, 2011; Bush, 2012; Ballesteros et al, 2014). Yet, whilst studies have investigated students' learning experiences of palliative care education (Ballesteros et al, 2014), there is a dearth of empirical evidence of the effectiveness of education initiatives on professional practice and patient outcomes. As such there are implications for strategically developed programmes of educational research which, in light of the dynamic, evolving nature of palliative care, are also sustainable.

Limitations

The limitations of this study should be acknowledged. The small sample of self-selecting students drawn from a single institution in a particular geographical location introduces positive response bias and means findings may not be generalisable. Furthermore, whilst interview data may be illuminative and enlightening, it ought not "be treated as valid in their own terms and thus beyond assessment and explanation" (Hammersely and Atkinson 1995, p: 156). Moreover, there may be inconsistency between what people say they and how they act. Nevertheless, the sample size is in accord with exploratory qualitative research and in terms of meeting the study's aims,

adequate. Moreover, participants were exposed to practices across geographically and socio-economically diverse locale. Arguably their insights are valuable, have some commonality, and connect with findings from earlier studies.

Conclusions

This paper reported insights into and understandings of palliative care from the perspective of final year adult field nursing undergraduates'. In the wake of widely expressed concerns about the state of contemporary nursing found in the UK media the findings are positive for they indicate that participants in this study appreciated and valued compassionate person and family centred care. Yet the findings also illuminate where undergraduate nurse education may be further enhanced. Certainly gaps are apparent for their accounts displayed negligible contemplation of care from the point of diagnosis, quality of life enhancement, ethical dimensions of care, shared decision-making, multiprofessional working, social and spiritual aspects of holistic care and advance care planning. Given ageing populations, escalating chronicity, greater reliance on institutional care, not just across the developed world, and the associated impact on and potential for general nurses' roles this is important.

In view of the policy drive for more generalist palliative care the findings from this study lend support to arguments and strategic initiatives for enhancing the nature and quality of palliative care education (Department of Health, 2008; Watts, 2013). Yet, at the level of service organisation and delivery, for this is where students gain their clinical experience, the need to value the significance of therapeutic relationships, ensure improved continuity of care and excellence in student support and recognise the impact of role modelling cannot be overlooked.

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