Survey of educators’ end-of-life care learning needs in a Canadian baccalaureate nursing programme

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Abstract

Aim: To examine the potential need for faculty development in end-of-life care (EOLC) of theory and clinical educators in a collaborative bilingual undergraduate nursing programme in a Canadian university.

Method: A purposive sample of 53 Anglophone and Francophone theory and clinical educators completed the Palliative Care Quiz for Nursing, the Frommelt Attitude Toward Care of the Dying Scale and an adapted Educators Educational Needs Questionnaire (Patterson et al, 2007). Results: Results indicated that educators held positive attitudes towards caring for dying patients and had modest knowledge levels. Participants identified personal educational needs, preferred learning formats, support and barriers to teaching EOLC and to their participation in continuing educational programmes. Strategies to enhance the teaching and learning of EOLC content in the theory and clinical context were suggested. Conclusion: Nurse educators require time, opportunities and relevant resources to develop the competencies required to support the theoretical and experiential learning of students in EOLC. Recommendations include a variety of approaches for faculty development initiatives, including face to face and virtual, which allow nurse educators to share expertise.

Key words: Curriculum content, Educators, End-of-life care, Learning needs, Nursing programmes, Palliative care

Current trends in demographics and types and frequencies of disease in Canada and the world reflect an ageing population and a rising incidence and prevalence of cancer and other progressive life-threatening chronic diseases (World Health Organization, 2004; Haydon et al, 2006; Statistics Canada, 2007). This new reality requires all health professionals to shift their focus from only curing disease to also managing symptoms, maximizing function, and enhancing or maintaining quality of life. In Canada, priority has been given at the national level to the improvement of education of healthcare providers in palliative and end-of-life care (EOLC) (Health Canada, 2001). A national project, Educating Future Physicians in Palliative and End-of-life Care (EFPPCEC, 2004), which initially focused on the education of medical students, has sparked some curriculum reforms and interest across the country in other healthcare disciplines.

However, there is wide variation in the degree to which specific theory and clinical practice is part of undergraduate nursing curricula (Manias et al, 1997; Brajtman et al, 2007). This situation exists despite the expectation that graduating students meet the current standards of core competencies in end-of-life nursing care as determined by the Canadian Nurses’ Association (2003). The frequency and continuity of contact that nurses have with their patients makes their role central to the provision of care to the terminally ill and their families (Vachon, 2001). However, despite societal expectation that nurses have the knowledge and skills necessary to care for dying patients and their families, nursing education may not adequately prepare nurses for this critical role (Ferrell et al, 2000; White et al, 2001). The need for additional education in EOLC has been identified as a major concern of graduate nurses providing care for terminally ill patients in diverse settings, and a range of educational interventions have been developed to enhance nurses’ knowledge, attitudes and skills in this critical area (Samaroo, 1996; Adriaansen and Frederiks, 2002; Loftus and Thompson, 2002; Meraviglia et al, 2003).

Nurse educators recognize the need to prepare undergraduate nursing students to acquire the relevant attitudes, knowledge and skills in various aspects of EOLC, such as effective pain and symptom management, supportive care interventions, ethical frameworks and the use of therapeutic communication skills (Sherman et al, 2004; Brajtman et al, 2007). Nursing students also need to be involved in learning experiences that facilitate an understanding of the relationship between relief of suffering and promotion of quality of life to patients’ and families’ psychosocial, spiritual, cultural and bereavement needs (Coyle, 2006).

To date, studies have focused on assessing
nursing students’ EOLC knowledge, skills and/or attitudes (Arber, 2001; Mallory, 2003), the amount and distribution of teaching that students receive in palliative care during their training (Lloyd-Williams and Field, 2002) and exploring new pedagogic strategies to enhance learning (Johnson and Jackson, 2005). Few studies have addressed the readiness and ability of the educators themselves to teach this content. It is assumed that nurse educators will have the knowledge required to teach EOLC, when in reality they may not feel adequately prepared to teach these specific competencies and may require additional education in this area (Sherman et al, 2004; Sullivan et al, 2005).

To address the potential need for faculty development in EOLC, a learning needs survey was conducted with theory and clinical educators in a collaborative bilingual undergraduate nursing programme in a Canadian university. The objectives of the survey were to assess:

1. Educators’ current attitudes and knowledge related to EOLC using the Palliative Care Quiz for Nursing (PCQN) (Ross et al, 1996) and the Frommelt Attitude Toward Care of the Dying (FATCOD) scale (Frommelt, 1991)
2. Their perceived specific learning needs
3. The resources and support required to teach and integrate EOLC content into the curriculum using an adapted version of the Educators’ Educational Needs Questionnaire (Patterson et al, 1997).

Educational needs assessments are necessary to identify preferred content and format of educational interventions, and to guide the development of programmes targeted at participants’ identified learning needs, preferences and work environment (Grant, 2002). This information can provide the basis for the development of educational interventions to enhance educators’ competence to teach and model key aspects of EOLC, and to effectively integrate the content into the curriculum.

**Methods**

A survey method was employed at the three sites of the baccalaureate 4-year programme, offered in both French and English. Participants included all full-time and part-time theory and clinical educators. Surveys were distributed in mailboxes and included an information letter explaining the purpose of the study and a request for completed anonymous surveys to be returned to the nursing faculty offices. To increase the response rate, an email reminding them of the survey was sent to all educators 3 weeks later (Dillman, 1978). Ethical approval for the study was received from the academic institutions’ research ethics boards.

**Measures**

The measures used in this study assessed educators’ attitudes, knowledge, learning needs and teaching challenges in the area of EOLC. All measures, excluding one, were available in English and French.

**Palliative Care Quiz for Nursing (PCQN)** (Ross et al, 1996): The PCQN is a 20-item true, false, and don’t know quiz, which takes approximately 20 minutes to administer. It is used to assess nurses’ knowledge of palliative care (the basic type of information required for entry to practice), identify misconceptions and stimulate discussion. It can also be used to assess learning needs, as a teaching tool, and can contribute to the evaluation of educational programmes related to the provision of palliative care. It is widely used in Canada, and has been translated for use in China, Taiwan, and for the Francophone nursing community (Carroll et al, 2005). It has shown positive item–total correlation coefficient and high internal consistency, validity and test–retest reliability.

**Frommelt Attitude Toward Care of the Dying (FATCOD) scale** (Frommelt, 1991): The FATCOD instrument consists of 30 Likert-type items scored on a five-point scale. It is used to assess nurses’ attitudes towards care of the dying and their families, with higher scores reflecting more positive attitudes. Possible scores range from a low of 30 to a high of 150. Results can provide educators with direction for course content development. The content validity index was 1.00 with an inter-rater agreement of 0.98. A Pearson coefficient of 0.90 indicated reliability. This tool has not been translated into French and can therefore only be administered in English.

**Educators’ Educational Needs Questionnaire**: A survey of the EOLC educational needs of long-term healthcare providers, developed by Patterson et al (1997), was adapted for use in this project. The questionnaires were coded to ensure anonymity. Questions asked about location and type of programme, courses taught, academic preparation, clinical experience, personal educational needs in EOLC, preferred learning format, and barriers to participation in educational programmes. Participants were also asked to provide additional comments in the sections related to educational needs in EOLC, preferred learning format, and barriers to participation in educational programmes.

*It is assumed that nurse educators will have the knowledge required to teach EOLC*
Analysis
Content analysis was used to analyse data received from the open-ended questions (Polit and Beck, 2004). Descriptive statistics were used to analyse the demographic data, survey questions and data obtained from the PCQN and FATCOD.

Results
Of the 195 surveys distributed to all sites and programmes, 53 were returned (27% overall response rate). The response rate of full-time educators was 18/37 (49%), and part-time educators 35/158 (22%). The results reported reflect the combined responses of all four sites and programmes involved in the survey.

Palliative Care Quiz for Nursing (PCQN)
Analysis of the PCQN scores revealed a mean score of 12.8 out of a possible 20. One participant did not respond to this tool, therefore n=52. Table 1 shows examples of PCQN statements. The eight items in the table reflect the highest and lowest scores achieved by the educators.

Frommelt Attitude Toward Care of the Dying Scale (FATCOD)
The total score was determined by summing item scores on this Likert scale (Polit and Beck, 2004). Although Likert scales are considered to be ordinal, they have frequently been treated as interval data, and this has not been found to jeopardize the statistical analysis (Polit and Hungler, 1995). The FATCOD mean score was 132 out of a possible highest score of 150. Table 2 shows examples of FATCOD statements with participants’ responses.

Educators’ Educational Needs Questionnaire (Patterson et al, 1997)
Participants were asked a series of closed and open-ended questions related to demographics, if they were involved in teaching activities related to palliative care, and their perception of existing personal and organizational support and challenges to teaching this content.

Background of subjects
Of the 53 surveys returned, 18 were from teachers with full-time status and 35 were from part-time teachers. The majority (36; 68%) of participants were teaching clinical courses. Of those teaching clinical courses, 3% had a PhD, 33% a masters degree, 50% a BScN and 14% a diploma. The teachers were very experienced, with 28 (53%) having taught for at least 6 years while 25 (47%) had 0–5 years’ teaching experience. Thirty per cent had additional specialty training in palliative care, which varied from certification to ad hoc courses.

Teaching palliative care
Twenty-three respondents (43%) had taught content related to palliative care in the past year and 26 (49 %) had not. Four respondents (8%) did not answer the question. Twelve of the 53 (23%) felt very well prepared to teach students to care for the dying, 43% felt somewhat prepared and 34% did not feel well prepared.

Teaching palliative care: open-ended responses
Educators teaching palliative care: The overriding impression from the open-ended responses of those who taught this content (19 of the 23 who responded) was that these educators saw the possibilities that existed to enhance the teaching and learning of EOLC. Participants suggested focusing on clinical conferences, identifying relevant patients in the clinical setting, encouraging students to communicate with patients and families about dying, allowing students to reflect on their experiences and their emotions, learning from other nurses, performing care after death, and including guest speakers in clinical conferences.
**Educators not teaching palliative care:** Responses from the 12 respondents included comments such as: no interest in EOLC, EOLC not relevant, and EOLC not a priority.

**Support for student education in palliative care**
Participants were asked to identify their perception of support (almost none, some, a great deal) for student education in palliative care in their institution. Of the 44 who responded, 12 felt there was no support, 26 some support and 6 a great deal of support. Participants were asked to comment on their support for and barriers to teaching palliative care.

**Support for teaching palliative care content**
Participants felt that they could access support from nursing faculty with expertise and from clinical experts in the agencies, such as those in acute care hospitals. For example, 9 participants stated that they could access nursing faculty with expertise; 11 accessed clinical experts in agencies; 2 mentioned having flexibility in courses to add content or learn about resources; 3 described being able to access resources; 1 recalled a supportive 4th-year course coordinator. Table 3 provides examples of comments expressed by the educators that reflect their perceptions of greatest support for teaching palliative care at their educational institution. To ensure anonymity, participants are identified only by programme and full-time or part-time status.

**Resistance to student education in palliative care**
Participants were asked to identify their perception of resistance (almost none, some, a great deal) to education in palliative care in their institution. Of the 39 respondents, 33 felt there was no resistance, while 6 felt there was some.

**Barriers to teaching palliative care**
Participants identified specific barriers to teaching palliative care. These centered on the lack of a formal plan to integrate EOLC content in the current curriculum (8), and no room or time to add anything else to the curriculum, whether in theory or clinical courses (13). Table 3 shows examples of comments expressed by the educators that reflect their perceptions of barriers to teaching palliative care at their educational institution.

**Preferred learning formats**
Participants were asked in which format they would like to learn palliative care and to rank the

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**Table 2. Examples of FATCOD statements and composite teacher responses**

| I would be uncomfortable talking about impending death with the dying person |
|-----------------------------|---------------------|---------------------|---------------------|---------------------|---------------------|
| Strongly disagree | Disagree | Uncertain | Agree | Strongly agree |
| 19 (37%) | 15 (29%) | 4 (8%) | 11 (21%) | 3 (6%) |

| The nurse should not be the one to talk about death with the dying person (n=52) |
|-----------------------------|---------------------|---------------------|---------------------|---------------------|---------------------|
| Strongly disagree | Disagree | Uncertain | Agree | Strongly agree | Not applicable |
| 33 (64%) | 18 (35%) | 1 (2%) | 0% | 0% |

FATCOD = Frommelt Attitude Toward Care of the Dying; *Composite scores of all programmes; n=52

**Table 3. Examples of support [Q16: added because it reads better - ?OK] and barriers to teaching end-of-life care**

**Support**
- ‘In a medical unit I have encouraged students to reflect on their emotional responses to dying patients and to interact with these patients and their families.’ *(English programme, part time)*
- ‘Colleagues discussing what techniques they use with teaching students.’ *(English programme, full time)*
- ‘Freedom to teach any related nursing issue in the clinical area.’ *(English programme, part time)*
- ‘Il y a toujours des possibilités de demander de participer aux activités de formation en général, y compris en soins palliatifs.’ *(French programme, part time)* *(Translation: There are always possibilities to ask to participate in activities for your development in general, including palliative care.)*
- ‘We have some faculty with a keen interest in the topics and much clinical expertise.’ *(English programme, full time)*
- ‘I suggest a palliative care teaching and research group such as the history of nursing research unit. We have such wonderful professors who specialize in palliative care yet their knowledge and resources do not appear visible to students on all levels of study.’ *(English programme, part time)*

**Barriers**
- ‘I integrated death and dying into the first year nursing course, but it was taken out when another prof took over!’ *(English programme, full-time teacher [Q17:delete for consistency with other comments, or is this intentionally different]*)
- ‘La résistance des collègues et l’organisation du curriculum.’ *(French programme, full time)* *(Translation: The resistance of colleagues and how the curriculum is organized.)*
- ‘Competition with other topics for curriculum time and space. Lack of a clear plan for how, when and what specific topics and competencies will be included.’ *(English programme, full time)*
- ‘Time constraints within the curriculum and when palliative care should be approached.’ *(English programme [Q18: added for clarity - ?OK], full time)*
choices from seminars, conferences, case studies, written information, lectures and online resources. Seminars were ranked first overall. Thirty-five (70%) of the 50 educators who responded ranked seminars as first, second or third choice. Conferences were the second choice, and a total of 28/44 (64%) respondents ranked them as first, second or third choice. Online resources were ranked as a first choice by only one educator, and by only 18/42 (43%) as first, second or third choice.

Respondents also identified factors that prevented them from participating in palliative care education activities. Conflict with work schedule was ranked first: of the 45 who responded, 26 (58%) ranked it first. Location of educational activity was ranked first, second or third by 18 (51%) of the 35 who responded, while timing of educational activities was ranked first, second or third by 26 (76%) of the 34 who responded. Language of instruction was ranked first, second or third by 18 (62%) of the 29 who responded.

Palliative care content desired
Participants’ responses were divided into physical, psychological, sociocultural and spiritual domains. These are illustrated in a model developed by the Canadian Hospice and Palliative Care Association (CHPCA) to reflect the complex needs of persons living with complex illnesses (CHPCA, 2002) (Figure 1). This model was developed through a national consensus building strategy by the CHPCA, is applicable to all persons with an illness, and represents the four domains of the needs of the person being cared for (CHPCA, 2002).

Figure 1 shows the percentages of participants who expressed a wish for specific content in the selected domains. Only those referring to – questions, curriculum content, items, needs? – please specify in which more than 50% participants responded have been included.

Resources required for the integration of palliative care content into teaching
Participants were asked to identify the resources required to integrate palliative care content into their teaching. They were provided with a list of items and asked whether they would use them in their teaching. The results were as follows: audiovisual 34/53 (64%), access to clinical experts 41/53 (77%), case studies 39/53 (74%), online learning 29/53 (55%), practice guidelines 38/53 (72%) and published literature 40/53 (75%).

Items ranked first, second or third in descending order were: clinical experts 34/41 (83%); case studies 29/39 (74%), practice guidelines 26/38 (68%), audiovisual material 22/34 (65%), published literature 21/40 (53%) and online learning 15/29 (52%).

Discussion
At various times during their programme, in almost every context of care, student nurses may encounter individuals and their families facing life-threatening illness, and/or be involved in the care of those who are imminently dying. It is therefore essential that theory and clinical nurse educators be adequately prepared in EOLC throughout the nursing programme, and have access as necessary to relevant teaching resources and faculty and clinicians with additional EOLC expertise.

While perceived learning needs assessments in EOLC have been conducted in many contexts with pre- and post-licensure healthcare students and practising clinicians (Samaroo et al, 1996; Ury et al, 2000), this study is one of the first to examine the learning needs of theory and clinical nurse educators themselves, their attitudes towards caring for the dying, and their basic knowledge in palliative care nursing. The results of the study highlight not only the specific learning needs of educators in EOLC, but also the personal and organizational support and challenges that influence the learning and teaching of this important subject, with specific implications for teaching and faculty development. This information can be used to create feasible, acceptable and meaningful
initiatives for faculty, which will ultimately influence the quality of the nursing education received by students.

Identifying specific learning needs
The majority of the educators held positive attitudes towards caring for the dying, as evidenced by the scores on the FATCOD, but achieved only average scores in the PCQN. The need to acquire additional specific knowledge in EOLC was also reflected by the topics identified by the participants, which reflected their particular learning needs. Although there does not appear to be a direct relationship between the scores achieved on the FATCOD and PCQN and many of the identified topics, this could be a reflection of the specific subjects addressed by the instruments.

The topics are illustrated within a model that reflects the physical, psychological, sociocultural and spiritual dimensions and needs of persons living with complex illnesses (Figure 1). The ‘pie’ was used as a framework to organize the EOLC topics identified by educators as areas where they required further knowledge and skill, such as cultural influences, the paediatric population, pain management and suffering. The topics address many of the essential aspects of EOLC illustrated by the model. Thus, enhancing nurses’ knowledge in these areas can contribute to the provision of comprehensive quality care for patients facing life-threatening illness, regardless of age or context of care. This model can also be used to guide the development of educational interventions for students and educators that reflect a holistic approach to care, which recognizes and integrates the dimensions of the person and the influence of community, care setting and environment on the individual (Hall et al, 2008).

Addressing support and barriers
Participants identified various personal and organizational support and barriers that influenced their opportunities to engage in palliative care education activities, and also impacted on their teaching of this subject, such as competing demands and lack of time to devote to continuing education activities (Table 3).

Consequently, organizers of activities need to take into account [Q4: reworded for clarity – is this what you mean?] factors such as work schedules, the location of the activity, timing and the language of instruction. For example, the language of instruction is a major consideration in a school of nursing with French and English programmes. Devoting a faculty professional development day to the teaching of EOLC can bring together educators to address topics related to perceived needs in a desired format, and developing online resources that educators can access at their convenience, are strategies that may be used to address several of the barriers related to time and competing demands.

Opportunities to teach student nurses can also be influenced by the reality of crowded curricula, which some participants identified as a barrier to teaching EOLC [Q5: is this what you mean?]. However, opportunities to integrate EOLC into the theory component of many courses do exist. For example, educators teaching students about cardiac and renal disease can also include content related to the role of palliative care when these diseases become end stage, and consult faculty with EOLC expertise for additional advice.

Overcrowded curricula and limited time and human and financial resources do indeed present challenges for faculty engaged in teaching and supporting students [Q6: reworded for clarity – is this what you mean?]. However, these issues and concerns are not unique to this institution, as many schools of nursing currently face several challenges related to shortages of staff and pressure on clinical facilities and instructional resources to meet increasing student enrolment in response to public and policy demands for more nurses (Oermann, 2004). Nevertheless, from examination of the support for and barriers to teaching EOLC, it is clear that many opportunities exist in the clinical and academic setting. Whether these opportunities are utilized seems to depend on the support that educators perceive they have from, for example, coordinators or the programme in general, in terms of the transparency of EOLC in the curriculum. If the perception is that opportunities for educators to bring EOLC to students are not prevalent, then teachable moments will be missed.

Providing opportunities for students
‘Care of the [Q7: inserted for clarity - ?OK] dying patient and family are inevitable in the nursing profession. Learning the skills and coping mechanisms is a must for nurses, starting from the undergraduate programme’ (English programme, part time).

Findings indicated that nurse educators appreciated the importance of providing their students with education in EOLC, recognized the possibilities that currently exist to enhance the teaching and learning of this subject, and believed that it was important to identify [Q8: reworded for clarity – is this what you mean?] ‘teachable moments’. They recommended focusing on
Participants identified seminars and conferences as their most preferred learning formats. Clinical conferences, identifying relevant patients in the clinical setting, encouraging students to communicate with patients and families about dying, allowing students to reflect on their experiences and their emotions, learning from other nurses, performing care after death, and including guest speakers at clinical conferences.

Many of these educators teach and supervise students in the clinical area where encounters with death and dying occur. It is during these encounters that students may experience feelings of anxiety, helplessness and incompetence if they feel that they do not have enough knowledge of EOLC to provide care that meets the needs of the dying patient (Cooper and Barnett, 2005). Consequently, clinical professors play an active and significant role in addressing students’ experiences and providing appropriate supportive interventions (Cooper and Barnett, 2005; Allchin, 2006). While essential information on EOLC can be acquired in theory classes, students must also have the opportunity to apply their knowledge in the clinical context (Lloyd-Williams and Field, 2002).

Findings from previous studies indicate that the arts and humanities can also be used successfully in teaching and learning contexts with nursing and other healthcare students to make it easier for them to share their feelings about the various life situations depicted in the arts and literature, as well as the real-life experiences they evoke (Johnson and Jackson, 2005; Hall et al, 2006a). Additional strategies shown to be effective in supporting student learning of the various dimensions of EOLC include assignments that encourage personal reflection (Dakin, 2003), participation in virtual online modules (Hall et al, 2006b) and the problem-based learning approach (Wong et al, 2001).

Implications for faculty development
Participants identified seminars and conferences as their most preferred learning formats, suggesting that interactive face-to-face forums can provide educators with opportunities to discuss teaching experiences and reflect upon their practice. In this study, the online learning format was identified as the least preferred learning method, possibly reflecting participants’ personal experiences and comfort level with computer technology. Faculty development programmes that involve online learning methods would therefore need to incorporate opportunities to engage in user-friendly online activities that allow them to increase their abilities and confidence (Stodel et al, 2006). Participants also valued learning from other faculty and clinicians with EOLC expertise in the larger community. Experienced faculty can offer guidance and resources to assist and support educators with their individual learning goals and efforts to integrate EOLC into an already established curriculum.

Providing opportunities such as workshops and professional development days for nurse educators to reflect upon and discuss teaching experiences and to learn from each other can support the development of a nurse educators’ community of practice in EOLC. Communities of practice are ‘groups of people who share a concern or a passion for something they do and learn how to do it better as they interact regularly’ (Wenger, 2006). Membership of this type of network implies a shared interest or commitment to a specific interest, regular engagement in interactive discussions with the purpose of helping and learning from each other, and the development of a shared repertoire of resources, which may include tools, stories, experiences, and strategies for dealing with specific problems (Wenger, 2006).

Ideally, educational programmes should consider combining several learning formats and components that can provide educators with opportunities to enhance their knowledge of EOLC, and learn about innovative teaching strategies based on learning objectives and students’ learning and support needs (Sullivan et al, 2005). Faculty development programmes in EOLC that integrate multiple approaches can enhance the sharing of expertise, knowledge, and ideas around EOLC and pedagogic best practices, and contribute towards a collaborative solution to specific EOLC teaching challenges.

Limitations
Study participants comprised nurse educators from only one academic institution, consequently the generalizability of the findings is limited. Also, the low response rate of 27% means that the sample was not representative of all the educators: it is possible that only those with a specific interest and/or currently teaching some degree of EOLC content completed the survey. Thirty per cent of respondents indicated that they had previously received education in EOLC, and this may have influenced the nature of their educational needs and their scores on the PCQN and FATCOD.

The results should be interpreted with caution owing to the limitations of the instruments. The PCQN, for example, does not cover many of the domains of EOLC, including non-pharmacological management of symptoms,
comfort care, cultural and ethical issues and the role of the interprofessional team; consequently it may not reflect participants’ knowledge in these important areas. The FATCOD does not account for important influences on attitudes towards death and dying, such as culture and religion. The survey method of the Educators’ Educational Needs Questionnaire does not allow in-depth information regarding educators’ perceptions of their teaching experiences in EOLC, which may have been captured through focus groups and/or individual interviews, to be considered [Q10: reworded (where underlined) for clarity – is this what you mean?].

Conclusions are also limited due to unequal representation from the four sites of the programme, and missing data limit the generalizability of the findings. For example, when asked to rank the factors that prevented participation in palliative care educational activities, not all 53 participants responded. Despite these limitations, the researchers were provided with data that reflected the needs of educators for EOLC content, the formats in which they prefer to receive information, and the support and barriers influencing this process.

Further research is required to evaluate the outcomes of educational interventions on the knowledge and attitudes of educators, and to examine the influence of faculty development in EOLC on the attitudes, skills and knowledge of nursing students and their perceived competence to care for terminally ill patients and their families. It is also necessary to establish empirical evidence to ascertain how different approaches to teaching EOLC affect patient and family care outcomes (Jordan, 2000).

Conclusion

At various times during their programme, in almost every context of care, student nurses may encounter individuals and their families facing life-threatening illness, and/or be involved in the care of those who are imminently dying. Consequently, it is essential that theory and clinical nurse educators are adequately prepared to teach and model EOLC throughout the nursing programme, and have access as necessary to relevant teaching resources and faculty and clinicians with additional EOLC expertise.

The results of this study highlight the importance of preparing nurse educators to support the theoretical and clinical learning of students in EOLC, and of the need to provide them with the time and relevant resources to develop these competencies. Educators who are able to facilitate and teach EOLC can prepare students to graduate with the fundamental knowledge and skills required by all nurses to meet the multiple challenges involved in providing professional and compassionate care for terminally ill patients and their families across the lifespan and in varied care settings. ☑

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Further research is required to evaluate the outcomes of educational interventions on the knowledge and
Research


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