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# Examining the Satisfaction Levels of Hospice and Palliative Care Nurses in Education, Clinical Confidence and Knowledge of Self Care Practice

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ABSTRACT

The purpose of this descriptive exploratory research study was to measure hospice and palliative care registered nurses self-reported information on end of life education and self- care practices including overall satisfaction with end of life education, self-rating of clinical confidence and knowledge of self-care practice. As no tool for measuring this was found in literature, this study included development of a new survey tool. Participants were solicited on a volunteer basis at end of life conferences and professional meetings for a period of ninety days. A total of 88 surveys were returned. Results revealed that the majority of respondents reported the primary contributor of knowledge in end of life care was through their job, followed by attendance at a conference, and through self-study. Over 67% of nurses rated their knowledge of self-care as "very good" or "excellent", and over 55% rated their overall satisfaction with end-of-life education as "very good" or "excellent".

*Keywords:* end-of-life education, nurse satisfaction, Watson's theory of human caring science

# EXAMINING THE SATISFACTION LEVELS OF HOSPICE AND PALLIATIVE CARE NURSES IN EDUCATION, CLINICAL CONFIDENCE AND KNOWLEDGE OF SELF CARE PRACTICE

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Doctor of Nursing Practice:

We, the undersigned, certify that the project of the following student meets the required standards of scholarship, format, and style of the university and the student's graduate degree program for the awarding of the doctoral degree.

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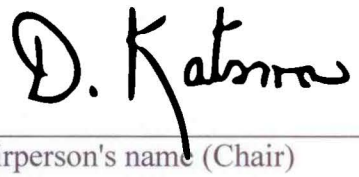

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# CHAPTER 1: INTRODUCTION

Improving end of life care education for nurses is imperative, as the nation's population ages. Despite efforts since 1997 (IOM, 1997), research has shown that there are not enough nursing professionals who have knowledge and skilled performance in end of life caring practices (IOM, 2014). Due to advances in healthcare and medicine nurses are now caring for more patients who are seriously and terminally ill. With nurses playing a key role in providing end-of- life care it is critical that they receive the appropriate education, and support.

End-of-life nursing care is a recognized nursing specialty and encompasses palliative care, hospice care and comfort care (Ferrell & Coyle, 2010). Although individuals at the end of life share biological and physical similarities, death is a uniquely individual experience that demands clinically competent nursing care. Both the End-of-Life Nursing Education Consortium (ELNEC) and Education in Palliative and End-of-Life Care Programs continue to provide education with an overall goal of increasing knowledge and competency (Callahan, et. al, 2011). While there are national programs like ELNEC, it is clear these programs and other forms of education are not reaching the growing number of nurses who will need to care for patients at the end of their lives (Dunn, et. al, 2005).

Providing care for the seriously and/or terminally ill adult is challenging for the unprepared nurse and may lead to inappropriate symptom management, compassion fatigue, and job dissatisfaction (Abendroth & Flannery, 2006). Improving care of the dying adult requires enhanced knowledge of physical, psychosocial and spiritual aspects

of care as well as attention to the support mechanisms available for the nurse delivering the care. Lack of clinical confidence and the inability to recognize normal versus abnormal aspects of the patient dying experience are an unfortunate consequence of insufficient end of life nurse education (Schreiber & Bennett, 2014). Lack of nurse preparation and education on meeting the patients' medical, spiritual and psychosocial needs may contribute to undue patient suffering such as inadequate pain management (Sinatra, 2010).

## Statement of Problem

Challenges exist for the unprepared nurse in providing comprehensive end-of-life care for patients and clients. Nurses working in community based hospice and palliative care settings routinely provide end-of-life care, but knowledge acquisition and care delivery practices are varied within each healthcare system (Hinds & Maghani, 2014). While the transition to the death event is a natural process and is not considered a medical event; caring for the dying requires a blend of emotional support, compassion, empathy and duty to deliver nursing care that is based on science. There is no literature available that examines how nurses working in hospice and palliative care gained their knowledge, their clinical confidence, or their understanding of self-care.

## Purpose

The purpose of this descriptive exploratory research study was to examine hospice and palliative care nurses' self-reported satisfaction levels of their end-of-life knowledge, clinical confidence and self-care practices. This study examined the caring practices of nurses to determine knowledge on end-of-life care, clinical confidence and

knowledge of self-care practices was acquired. This study provides information that may contribute to improvements in teaching and caring practices related to end-of-life care.

Nurse Theorist

Recognizing that the essence of comprehensive, patient centered care is a blend of art and science, the project used aspects of Jean Watson's theory of human caring science. The beliefs and assumptions that underlie human caring science are deeply embedded in hospice and palliative care nursing, as healing is different than curing. The philosophy of hospice and palliative care nursing, is to provide comprehensive care for the dying that is carative not curative. Watsons' caring science framework of supports the interconnectedness, the knowing/learning exchanges, and is exemplified in the hospice nurse/patient relationship (Hills & Watson, 2011).

The role of the professional nurse working in end-of-life care includes providing clinical interventions and creating a caring, healing, supportive environment. Human caring is more than emotion and duty; and thus, deserves a well-defined nursing theory to assist with validation of concepts (Petiprin, 2015). Jean Watson's theory of human caring provides a framework of caring factors which she calls "Caritas Processes" or practices. Originally conceptualized and introduced in the late 1970's, Watson's journey began as an interpersonal process to seek clarity on the role of the nurse, as it relates to practice, education and research. Her intent was to examine the problems and shared experiences that were imbedded in the profession of nursing, and to ask if there was a way to place well-defined constructs around existential parameters, such as the presence of caring (Watson, 2012).

The structural overview of Watson's theory is that the *process of human caring* is an application of art and science. Watson grounds her theory in the notion that the nurse has sufficient clinical competence and knowledge to provide comprehensive care for they dying individual (Watson, 2012). Hospice and palliative nursing care provides nursing interventions that increase patient comfort such as compassionate presence and pain and symptom management (Ferrell & Coyle, 2010). The theory of human caring science is deeply rooted in the philosophy of hospice nursing care and is inherently intertwined within the agreement to care for others in all stages of health and illness. Human caring science has developed ten Caritas processes that offer the individual guidance on shaping interpersonal beliefs, ways of knowing and transpersonal interactions (Watson, 2012).

Application of the caritas process that supports the patients' expression of feelings, offers the hospice nurse an opportunity to build a relationship based on trust and encourages open communication (Watson, 2012). This exchange between the hospice nurse professional and the patient results in creating a positive space/energy between nurse, patient and environment; that is an opportunity for self-growth and healing. In this sacred space human caring is exemplified as the hospice nurse connects with the patient (Watson, 2012).

The foundation of Watson's theory rests on the knowledge that caring is a comprehensive way of knowing that incorporates philosophy, ethics and is applicable to hospice nursing as it cultivates hope (Watson, 2012). Recognizing that nurses are all unique but similar through their human experiences, Watson's theory reminds the nurse

that all humans are connected, and that this opens a sacred space between the hospice nurse and patient where healing may occur (Watson, 2012).

In comparison to other nursing specialties nurses working in hospice and palliative care are exposed to death and dying on a daily basis. This has been identified as a source of increased stress that leads to burnout and compassion fatigue (Rosa, 2014). The goal of applying a caritas process is to enhance knowledge of self and the influencers that prevent regular self-care practices, and offer the nurse an opportunity to align with the individual's caring self. Implementing self-care practice into daily activities offer the hospice nurse a chance to decrease strain and avoid emotional overload (Rosa, 2014).

Hospice nursing is a vocation based in scientific principles and caring presence. Thus, it is imperative that each nurse providing care for the seriously and terminally ill individual reflect on the precious nature of that interpersonal relationship. The theoretical context for creating a human caring environment for the dying individual is to broaden the provision of nursing care from symptom management to comprehensive care of the mind, body and spirit. Watsons' theoretical framework focuses on perspectives and opportunities for the hospice nurse to understand self and of the interconnectedness with others as interdependent in the cycle of care delivery (Caruso, et. al, 2008).

The basis of the caritas processes recognizes the person as a unique individual with their own value system, who in totality has hopes, dreams, beliefs and their own way of knowing. The caritas processes allow for a unique opportunity for nurses working in end of life care to acknowledge that individuals are more than their illness state, and are capable of healing even in the presence of physical deterioration and death. The essence

of human caring theory is to be open and to create a healing presence while understanding oneself and being other oriented. Watson's theory is predicated by the assumption that the nurse has sufficient clinical competence and the knowledge of self-care practices to provide clinically confident care for the dying individual (Watson, 2012).

Research Question

This research was conducted to examine the characteristics of nurses working in hospice and palliative care, as well as self-reported ratings of end-of-life knowledge, clinical competency and self-care practice.

## CHAPTER 2: LITERATURE REVIEW

Expressions of caring, empathy, and therapeutic, clinically appropriate nursing interventions must include those that will alleviate suffering and allow for a peaceful death. With multiple research studies confirming inadequate nurse education in end-of-life care, it is unknown how nurses working in the specialty of hospice and palliative care are acquiring the knowledge, clinical confidence and caring practice to provide comprehensive end-of-life care.

A descriptive cross-sectional study conducted by Schlairet (2008) on nurse characteristics and education experiences reported that participation in continuing education in end-of-life care courses support clinical competency and nurse knowledge. These findings are important to nurse education, as continuing education courses could be used to support the growth of hospice and palliative care nurse generalists. Perhaps

nurse educators, who work in the public and private sector, could be called upon to assist with designing and delivering curriculum to improve end-of-life education.

While some improvements have been made in nurse education in end-of-life care, improvements must accelerate to meet patient demand. An increasingly number of patients will need specialty care and thus, additional generalists must be trained to assist in delivering this type of care. Nurse education in end-of-life care must not be limited to a single event, but ongoing through-out one's career. As nurse education continues to evolve, so too should end-of-life nurse education practices. Improvements in end-of-life education and support of specialty training in hospice and palliative care are beginning to make a difference. The ELNEC program is an example of progress in end-of-life nurse education (Schlairet, 2008).

This research reported nurse competency and knowledge in end-of-life care were not dependent on formal education. Nurses who were clinically confident and knowledgeable providers did not consider formal education as a predictor of competency. This is likely due to the fact that professional and role development does not cease after our initial licensure. Nurses who were interested in the specialty of hospice and palliative care nursing evidently sought out opportunities for education and training, to benefit practice.

Analysis of end-of-life nurse education practices confirms a gap in nurse education practices. White & Coyne (2011) conducted a multi-state descriptive, cross-sectional study surveying oncology nurses. The purpose was to examine what respondents believed to be important in providing end-of-life care. Nurses were asked to

rank nursing skills and nursing knowledge in a variety of domains that are consistent with providing evidenced based end-of-life care. Nurses reported the top three areas of improvement and additional education support were: improving communication skills, improving clinical symptom management and knowledge and understanding terms related to end-of-life care (White & Coyne, 2011).

While symptom management was ranked as the primary area of improvement, communication practices specific to the dying process was deemed very important (White & Coyne, 2011). This is likely because in the acute care setting or outpatient oncology clinic, nurses would be providing care that is curative in nature. Discussions with patients would center on current events and current therapies, rather than their disease trajectory and prognostication. Training as an oncology nurse includes nursing interventions aimed at cure and at tasks directed at treatment of the body. Similar to nurses working in hospice and palliative care, oncology nurses receive basic training and orientation to their role; however, as reported in this research study, an enhanced commitment to education and training including therapeutic communication techniques is needed to support nurses in both specialties.

A comparative descriptive study by Thacker (2008) examined nurse behaviors and perceptions of advocacy when caring for the dying, in the hospital setting. Nurses were asked to report on support systems that promoted patient advocacy as well as perceived barriers to providing comprehensive end-of-life care. Nurses reported their co-workers and managers as supporting their clinical caring role and as patient advocate.

Perceived barriers to providing advocacy for patients at the end-of life were reported as physician influence, fear and lack of end-of-life education.

The study reported that more education is needed to support physician understanding of death and dying, and in acting as patient advocate, nurses can assist with providing education to all members of the healthcare team. Fear at the end-of-life is a common phenomenon and is related to loss of hope, inadequate knowledge and understanding of death and dying and lack of spiritual support. Families are often so focused on curative measures in the hospital setting that when the goals of care changes to comfort measures, or dying care, they have not had enough time to adapt, or process this change. Hospitals are meant for cure, and thus, when cure is not an option, patient and families must face this new reality (Thacker, 2008).

This research is important as it connects nurse advocacy, a caring practice, with caring for the individual at the end-of life, and confirms the need to provide end-of-life education and support. As reported in my study, the bulk of nurse knowledge in end-of-life care is obtained on the job. Healthcare organizations should support end-of-life education at the specialist and generalist level to promote best practices and improve end-of-life knowledge.

## CHAPTER 3: METHODOLOGY

A descriptive exploratory design was used to describe the contributors to end of life nurse knowledge, overall satisfaction with end-of-life education, self-rating of clinical confidence, and knowledge of self-care practice.

The Survey Tool

The "End of Life Nurse Education Survey Tool" (Appendix A) was developed specifically for this research study by the principle investigator as no tool was found. Variables contributing to the design of the tool include variances in practice site, and personal beliefs/experiences with death and dying; all factors considered very subjective in nature and difficult to quantify; thus the survey tool was developed using a likert scale to measure nurse satisfaction level with education, and self-care practices. Concepts from Watson's theory of caring were integrated into the survey.

The End-of-Life Nurse Education survey tool included eight demographic questions and three Likert scale questions to capture the characteristics and perceptions of the study participants. The data collection instrument created for purposes of this study had neither reliability nor validity. The survey tool utilizes a 5-items Likert quality rating scale, with choices spanning from very poor (1) to excellent (5). The End-of-Life Nurse Education survey tool collected the following demographic data: date, location where survey was distributed, age, gender, education level, number of years working in hospice and/or palliative care, employment status, HPCC certification status, and the perceived largest contributor to acquisition of knowledge in hospice and palliative care nursing.

The End-of-Life Nurse Education Surveys were collected electronically by the principle investigator. No other persons were utilized for this research project. All surveys remained anonymous, and were coded to protect from the release of information.

Threats to internal validity of the research project include selection bias. This study represented a convenience sample of survey respondents, solicited at a seminar and

events that exist solely to promote end of life nurse education. The survey asks respondents to perform self-ratings, which are influenced by a variety of factors and are difficult to quantify (Melynk & Fineout-Overholt, 2011).

Research Sample

The convenience sample was made of nurses working in hospice and palliative care. Participants were solicited during a 90-day period in August – October 2015. There were multiple attempts at encouraging participation in this research study, including face to face invitation at the End Of Life Nurse Education Consortium (ELNEC), social media postings, networking during chapter events hosted by the San Francisco Bay Area Chapter of the Hospice and Palliative Nurses Association (SFBA-HPNA) (sfbahpna.nursingnetwork.com, 2015), and virtual solicitation of members from the National Hospice and Palliative Care Nurses Credentialing Center (HPCC), (hpcc.advancingexpertcare.org). There were no exclusions characteristics for age, gender, ethnic or cultural backgrounds. All nurses contacted, irrespective of these demographics were encouraged to participate in the study.

Prior permission was obtained from the ELNEC coordinator for solicitation of volunteer study participants during the August 2015 conference in Kona, Hawaii, and from the President Elect of the SFBA-HPNA. None of the professional organizations in this study required IRB committee review approval prior to collecting data for this study. The settings described above are unique to a study on end-of-life nurse education practices, and offer an innovative perspective on clinical research. ELNEC events attract nurses from a variety of geographic settings (urban, rural, academic), clinical

backgrounds (oncology, home health, research) and education levels (associate degree, baccalaureate prepared, advance practice) and employment settings (hospital based, clinic based, freestanding hospice, not for profit/for profit hospice agencies), which add value to this capstone project. There were a total of 111 surveys returned and of those, 88 were complete and included in this study. Twenty-three surveys were excluded from the study because one or more questions were left unanswered.

### Data Analysis

Data synthesis began with survey review for legibility and completeness. All survey data was reviewed for completeness for inclusion in the study; resulting in an $n$=88. No incomplete or partially completed responses were accepted. After sorting respondent surveys for inclusion/exclusion, data was coded and entered into an excel spreadsheet to for reporting purposes. Frequencies and percentages are reported to describe the demographic characteristics of the survey respondents. The data was analyzed to provide the principle investigator with the self-rating satisfaction level of knowledge of self-care practices, self-rating of clinical confidence in providing end-of-life care, and self-rating of overall satisfaction with end-of-life education.

## CHAPTER 4: RESULTS AND DISCUSSION

Table 1 shows survey location, reporting frequency and overall percentages of participants. Most survey participants were in the "other" category which was made up of nurses recruited through social medic, network events and meetings.

Table 1

*Location where survey was distributed*

| | Frequency | Percent |
|---|---|---|
| ELNEC Seminar | 25 | 28.4 |
| HPNA Event | 6 | 6.8 |
| Other | 57 | 64.8 |
| Total | 88 | 100 |

A majority of respondents were female: Female *n*=83, Male *n*=5.

A majority of the respondents self-reported as older than 40 years at the time of the survey (Table 2).

Table 2

*Participants Age*

| | Frequency | Percent | Cumulative Percent |
|---|---|---|---|
| 20-30 | 1 | 1.1 | 1.1 |
| 30-40 | 9 | 10.2 | 11.3 |
| 40-50 | 23 | 26.1 | 37.4 |
| 50-60 | 38 | 43.2 | 80.6 |
| >60 | 17 | 19.3 | 100 |

The majority of persons responding to the survey education level was at or above the Baccalaureate level (Table 3).

Table 3

*Nurse Education Level*

| | Frequency | Percent | Cumulative Percent |
|---|---|---|---|
| LVN to RN | 0 | 0 | 0 |
| ADN | 10 | 11.3 | 11.3 |
| BSN | 26 | 29.5 | 40.8 |
| MSN | 37 | 42.0 | 82.8 |
| Doctorate | 11 | 12.5 | 95.3 |
| Other | 4 | .05 | 100 |
| Total | 88 | 100 | |

While Thirty-eight percent of the respondents reported that they have worked in hospice or palliative care for greater than ten years (Table 4), 61% had worked 10 years or less in the specialty.

Table 4

*Number of Years' Experience in Hospice or Palliative Care*

| | Frequency | Percent |
|---|---|---|
| < 2 | 12 | 13.6 |
| 2 - 5 | 16 | 18.2 |
| 5 - 10 | 26 | 29.5 |
| >10 | 34 | 38.6 |
| Total | 88 | 100 |

Sixty-seven percent of the nurses were currently employed in outpatient hospice or palliative care (Table 5).

Table 5

*Current Employment Status*

| | Frequency | Percent |
|---|---|---|
| Yes | 59 | 67.0 |
| No | 29 | 33.0 |
| Total | 88 | 100 |

Only 45.5% of the respondents reported certification (Table 6) and of that certification, 33% were CHPN and 13.6% were ACHPN (Table 7).

Table 6

*National Certification Status*

| | Frequency | Percent |
|---|---|---|
| Yes | 40 | 45.5 |
| No | 48 | 54.9 |
| Total | 88 | 100 |

Table 7

*Certification Type*

| | Frequency | Percent |
|---|---|---|
| CHPN | 29 | 33.0 |
| ACHPN | 12 | 13.6 |
| OTHER | 47 | 53.4 |
| Total | 88 | 100 |

Hospice and palliative care nurses were asked to select contributors to end-of-life education. The most frequent source reported by the participants as a primary contributor to end-of-life nurse knowledge was on the job training (n = 77; 76.2%). Due to question design, it is unclear whether these were classes taught on the job or job experience gained through practice. The second most frequent response about source(s) that contributed the most to the participants' end-of-life care nurse knowledge was attendance at a conference or seminar (n = 65; 64.4%). This high response is not surprising since so many participants were recruited from professional meetings and gatherings. The third most frequent source reported by the participants was self-study (n = 63; 62.4%). Four (0.04%) people out of *n*=88 participants indicated that all 9 sources contributed the most to their end-of-life care nurse knowledge (Table 8).

Table 8

*Contributors to Nurse Knowledge*

| | Frequency | Rank |
|---|---|---|
| Nursing School | 11 | |
| Conference/Seminar | 65 | 2 |
| On-line | 36 | |
| Job | 77 | 1 |
| New hire | 26 | |
| Self-study | 63 | 3 |
| Text | 25 | |
| Peer/Mentor | 55 | |
| Resource Guide | 26 | |

Incorporating self-care practices and health habits are essential for the nurse working in end-of-life care. The ongoing exposure to grief, loss and bereavement may contribute to emotional burn out. Table 9 represents respondents reported knowledge of self-care practice. None of the survey respondents self-rated as very poor knowledge of self-care practice.

Table 9

*Knowledge of Self-Care Practice*

| Likert Scale | Frequency | Percent |
|---|---|---|
| Very Poor | 0 | 0 |
| Poor | 4 | 4 |
| Good | 15 | 14.9 |
| Very Good | 36 | 35.6 |
| Excellent | 33 | 32.7 |
| Total | 88 | 100.0 |

Survey respondents' reported that the majority of individuals self-rated as clinically confident in providing end-of-life care. Of all responses, 77.2% participants reported very good to excellent clinical confidence (Table 10).

Table 10

*Clinical Confidence*

| Likert Scale | Frequency | Percent |
|---|---|---|
| Very Poor | 0 | 0 |
| Poor | 0 | 0 |
| Good | 10 | 9.9 |
| Very Good | 36 | 35.6 |
| Excellent | 42 | 41.6 |
| Total | 88 | 100 |

Only 6.9% of the participants reported poor or very poor satisfaction with end-of-life nurse education (Table 11).

Table 11

*Overall Satisfaction with End of Life Education*

| Likert Scale | Frequency | Percent |
|---|---|---|
| Very Poor | 1 | 1.0 |
| Poor | 6 | 5.9 |
| Good | 24 | 23.8 |
| Very Good | 31 | 30.7 |
| Excellent | 26 | 25.7 |
| Total | 88 | 100 |

This is the first study, to the principle investigator's knowledge, to explore the nurses self-rating of clinical confidence, knowledge acquisition and self-care practice.

The survey captured demographics, and revealed that the majority of nurses self-rated as knowledgeable, confident, satisfied providers who are aware of self-care.

While respondents reported job training as the primary contributor to nurse education, it is important to consider that "job training" in end-of-life care may equate to insufficient preparation. Job training practices vary from organization to organization, and are influenced by the clinical training, expertise and tenure of the clinical nurse manger and current staffing need. Nurse candidates interested in the field of hospice and palliative care come from all areas of nursing. There is a vast difference between working independently in the community setting and working in the acute care environment, where there may be adequate supplies and resources to assist with providing end-of-life care.

It is a positive finding from this study that nurses report knowledge of self-care practice. The concept of self-care was understood, but the question lies in the type of self-care practice and whether or not nurses regularly engaged in self-care. Although knowledge of self-care is important, performing actions to care for the self is important to maintain one's equilibrium in the highly emotional specialty of end of life nursing care, to avoid job burnout and compassion fatigue.

Limitations

A limitation of the study was the inclusion of a new tool without validity and reliability established. The study results may have been unintentionally influenced by the geographic location, the venue (ELNEC conference in Hawaii) and in the manner (face to face, social media, networking events) method of solicitation to participate. Invitation to

participate in this research study focused on individual's familiarity with end-of-life care as a nursing specialty; thus may have provided a broad enough representation of responses.

Threats to internal validity of the research project include selection bias. This study represented a convenience sample of survey respondents, solicited at a seminar and events that exist solely to promote end-of life nurse education. The survey asks respondents to perform self-ratings, which are influenced by a variety of factors and are difficult to quantify (Melynk & Fineout-Overholt, 2011).

## CHAPTER 5: CONCLUSION

This study explored hospice and palliative care nurses self-report of contributors to end of life education, clinical practice and understanding of self-care practice. By studying competent and expert nurses, we can see the paths they followed and possibl enhance opportunities for learning and knowledge development.

Since this study suggests nurses are learning on the ob, and learning increases when the individual reflects on their n experiences, n rse s could be encouraged to journal their reflections or have small seminar groups where they are able to discuss and reflect upon their experiences providing end-of-life care.

Managers and staff may want to introduce self-care practices on their unit. It may not be enough to know that the nurse needs self-care when dealing with the complexities of r idin c re r e d in d 1. Encouraging socialization, debriefing, r using c nsel rs en needed are all ways that managers and nurses can promote self-care in a stressful environment.

Staff can and should be acknowledged for their implementation of caring practices. The theory of human caring states instilling hope and faith can provide comfort to the dying patient. Developing relationships with patients is not only supportive of the patient but allows the nurse to share empathy and compassion. The nurse is in a unique and privileged position to see the patient and their family holistically and provide presence to help the patient find strength and courage.

While every piece of research on end-of-life care looks to undergraduate education as the solution for preparation, several factors need to be kept in mind. Undergraduate nurses are novices. One must question if they have the scaffolding to take up the demands required in end-of-life care. Nursing curriculum overload is a serious and significant problem. Designing appropriate curriculum for this level nurse is essential, with full knowledge that the complexity of this care is learned through experience. Methods of self-care would be helpful to the undergraduate student as they can be applied in many areas of their career.

The results of this study are limited by sample characteristics. The end-of-life education experiences explored in this study represent individuals' self-ratings of primary contributors to education, and their clinical confidence and self-care practices.

Future Study

For clinical practice implications, more research is needed to determine the type of self-study practices that were utilized. It is unknown what type of self-study guide or practice contributed to nurse knowledge, and if that resource was aligned with evidence based practice. It would be beneficial to continue research on the predominate

contributors to nurse end-of-life education, as the specialty field of hospice and palliative care nursing continues to develop.

Almost all nurses, at some point in their professional practice will likely encounter a patient who is seriously ill or dying. There is a space that is present in nurse end-of-life education; the place between pre and post nurse licenser curriculum and working as a professional nurse. At best, one can hope that the person providing that care has received adequate on the job training where best practices in end of life care are routine. As nurse professionals, identification of troublesome symptoms that require escalated management are essential to providing quality end of life care.

Nurse education should address the overwhelming need to prepare nurses in care of the dying. By learning from those who are walking the walk, we may be more effective.

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Appendix A

End of Life Nurse Education Survey

Today's Date: dd/mm/yy

1. Survey Location: __ ELNEC Seminar __ HPNA Event __Other
2. Your gender: __ Male __Female
3. Your age: __ 20-30 __ 30-40 __40-50 __50-60 __>60
4. Your nurse education level: LVN-RN ADN BSN MSN Doctorate Other
5. Number of years working in hospice and palliative care:
   <2 2 -5 5-10 >10
6. Are you currently employed as a registered nurse working in outpatient hospice and palliative care? Yes No
7. Are you certified by the HPNA/HPCC? Yes No
8. Of you are certified, what is your designation? CHPN ACHPN Other
9. As a hospice and/or palliative care nurse what source(s) contributed the most to your end-of-life education? (*You may choose more than one)*
   Nursing school Attendance at a conference or seminar
   On-line resource On the job training
   New hire or general orientation at workplace
   Self-study Text books Peer or mentor
   Resource guide

Please answer each question using the Likert scale:
(*Very Poor: VP, Poor: P, Good: G, Very Good, VG, Excellent, E)*

1. What is your knowledge of self-care practices?
2. How would you rate our clinical confidence level in providing end-of-life care?
3. How would you rate your overall satisfaction with the education you have received to care for your end of life patients?