Nursing Students' Comfort with Providing Palliative and End-of-Life Care

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Abstract

Limited education concerning palliative and end-of-life care has been identified as an ongoing challenge in baccalaureate nursing education. This mixed-methods research study explored fourth-year baccalaureate nursing students' self-efficacy and emotional intelligence in relation to their comfort in providing palliative and end-of-life care (PEOLC) for persons and their families. Bandura's self-efficacy theory was used as the theoretical framework, in addition to Salovey and Mayer's definition of emotional intelligence. Quantitative data was collected in the first phase using the following three instruments: The Palliative Care Self-Efficacy Scale; the End-of-Life Professional Caregiver Survey; and the 33-Item Emotional Intelligence Scale. Using Pearson statistical analysis there was evidence to suggest a statistically significant correlation between self-efficacy and comfort, as well as emotional intelligence and comfort of fourth-year nursing students in providing PEOLC for persons and families. Qualitative data was collected during the second phase with four themes having been identified: previous experiences with PEOLC enhance comfort; need for PEOLC nursing education and teaching-learning strategies; emotional impact of providing PEOLC, and comfort level decreases with difficult PEOLC conversations and situations. The findings supported the need for enhanced palliative and end-of-life education and supportive education strategies to ensure fourth-year nursing students have the perceived self-efficacy, emotional intelligence, and comfort in providing quality care to patients and their families.

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Chapter 1: Introduction

Background Information

In nursing education there are specific competencies outlined for the baccalaureate graduate nurse to promote safe and ethical nursing practice, which all programs are required to consider during curriculum design and development, program revisions, and ongoing evaluation (College of Nurses of Ontario, 2019, 2021, 2022a; Canadian Nurses Association, 2022a, 2022b; Canadian Association of Schools of Nursing, 2011, 2015, 2020). The primary goals of nursing education are to ensure that nursing students develop the required knowledge, skills, abilities, and affective attributes in order to practice professionally and safely while adapting to the ever-changing health care environment. To support the goals of nursing education, this research study focuses on analyzing study findings and providing recommendations which can influence future nursing programs. This has the potential to support nursing students' practice and impact the quality of palliative and end-of-life care provided for patients and their families.

A review of the literature reveals an area of nursing practice of particular challenge in which gaps have been identified for nursing students, and that is, the lack of knowledge and comfort when providing palliative and end-of-life care for persons and their families (Carvalho et al., 2020; Colley, 2016; Corcoran, 2016; Oluwatomilayo et al., 2014; Strang et al., 2014). Managing personal emotions about death and dying and having inadequate prelicensure education on end-of-life results in nursing students feeling ill prepared and uncomfortable to properly care for patients and their families (Dame & Hoebeke, 2016; Lippe et al., 2017; Strang et al., 2014; White & Coyne, 2011).

In their work, Gillan et al. (2014) identified how in undergraduate nursing program curricula there is a lack of content on end-of-life care. Subsequently, Corcoran (2016) and Gillan et al. (2014) claimed the literature supports the idea that undergraduate nursing students are not

adequately prepared to care for patients and their families during end-of-life. With the updates to entry-to-practice competencies for registered nurses related to this crucial area of nursing practice (College of Nurses of Ontario, 2019), continued reform in federal legislation involving medical assistance in dying (MAID), along with the rate of population composed of older adults in Canada (Statistics Canada, 2022), there is a need for baccalaureate nursing graduates to be comfortable and knowledgeable with providing quality palliative and end-of-life care (PEOLC). Also, with the increased death rates and ethical issues associated with the Covid-19 pandemic, the need for quality PEOLC has heightened (Wilson & Chan, 2022). The impact of the pandemic has caused changes to nursing education (Canadian Association of Schools of Nursing, 2020), created challenges for nursing students and healthcare workers (College of Nurses of Ontario, 2022b; Registered Nurses Association of Ontario, 2022), and created barriers related to the research process for graduate researchers (Flaherty, 2021; Levine et al., 2021; Ramos, 2021) interested in this area of study.

Problem Statement

As a nurse educator for more than two decades, this researcher has had the privilege of accompanying nursing students to the palliative-oncology clinical setting and, as well, teach a variety of courses containing PEOLC theory and concepts. Based on these experiences, students often express an array of emotions and lack of comfort when dealing with death and dying. They frequently question their self-efficacy, knowledge, and ability to communicate and manage their emotions in complex situations when providing care for persons and their families during end-of-life. Strang et al.'s (2014) research also supported this problem and discovered when the nursing students "encountered questions about death and dying, they described their thoughts as hovering between duty, demands, their own insufficiency and lack of experience, and the fear of death" (p. 198). As a result, a major concern relates to deficiencies in knowledge and the feelings of nurses

being unprepared for practice (Colley, 2016; Lippe et al., 2017). These deficiencies can result in inadequate care being provided to dying patients and their families (Colley, 2016; Lippe et al., 2017).

Purpose of the Study

The purpose of this mixed methods research study is to explore fourth-year baccalaureate nursing students' self-efficacy and emotional intelligence as they relate to their comfort in providing palliative and end-of-life care for persons and their families.

Research Question

The research question explored in this study is**:** What is the relationship between self-efficacy and emotional intelligence and fourth-year nursing students' comfort in providing palliative and end-of-life care (PEOLC) for persons and families? The hypothesis is: higher levels of self-efficacy and emotional intelligence will relate to greater comfort by fourth-year baccalaureate nursing students' in providing PEOLC.

Chapter 2- Review of the Literature

Search Description

The focus of this literature review was to review the theories related to the variables being investigated, the specific research variables, and practice applications revealed in the review. The approach was based on Cooper's (1988) taxonomy of literature reviews (as cited in Randolph, 2009). The following questions also guided the literature search: a) What are the central theories that have been used to explain self-efficacy, emotional intelligence, and comfort when providing PEOLC as it relates to nursing students? b) What are the lived experiences and/ or the effects of an intervention on self-efficacy, emotional intelligence, and/ or comfort of baccalaureate nursing students in providing PEOLC to persons and their families? c) What are the nursing implications and recommendations for future PEOLC education practices?

An electronic search of the academic databases involved CINAHL and ProQuest. The inclusion criteria for selecting literature included: a) Baccalaureate nursing students and PEOLC education, b) One or more variables related to self-efficacy, emotional intelligence, and comfort concerning providing PEOLC, c) Studies involving quantitative, qualitative, or mixed methods research. English language and full text peer-reviewed journal articles published since 2001 were reviewed. Literature to further explore the theories and associated theorists involving the research variables were also examined. Additional information was obtained through select internet sites including those of the Canadian Association of Schools of Nursing (CASN), Canadian Nurses Association (CNA), College of Nurses of Ontario (CNO), Advance Care Planning Canada, National Cancer Institute, and the Ontario Ministry of Health and Long-Term Care.

The theoretical framework used in this study is described in further detail, followed by review of the research associated with the following variables: self-efficacy, emotional

intelligence, and comfort involving nursing students providing PEOLC for patients and families. In addition, a review of the literature and national legislation on medical assistance in dying (MAID), the impact of the Covid-19 pandemic, and research on nursing education concerning PEOLC was conducted as each area relates to the purpose of this research study.

Theoretical Framework

Nursing practice experiences involving palliative care, and death and dying can evoke complex emotional responses on the part of the nursing student (Carvalho et al., 2020; Corcoran, 2016). It is this researcher's assumption that personal self-efficacy and the ability to manage emotional situations may be related to comfort levels of nursing students when providing PEOLC to patients and their families. As such, Bandura's (1977) self-efficacy theoretical framework was selected as the foundation for this research study. This theoretical framework is often studied in nursing curricula and has been used in nursing research on palliative care and self-efficacy (Adriaansen & van Achterberg, 2004; Phillips et al., 2011). Bandura's (1977) self-efficacy theory provides a thoughtful understanding and connection to the problem, purpose, and research question of this study (Grant & Osanloo, 2014).

Bandura (1994) has defined self-efficacy as a person's perceived capability to perform and influence events that impact their lives. Beliefs associated with self-efficacy thus determine how a person feels, thinks, and is motivated to behave in any situation (Bandura, 1994). Personal efficacy is based on four sources of information which include the following: performance accomplishments; vicarious experience; verbal persuasion and emotional arousal (Bandura, 1977).

According to Bandura (1977) the first source of information, performance accomplishments, is linked to personal mastery experiences. Bandura stated previous successes will increase mastery expectations, although challenges associated with experiences having a

negative impact will have an opposite effect. Similarly, the author described the timing and overall pattern of experiences will have an effect on personal efficacy. The positive impact of behavioral functioning and performance accomplishments can also have a transfer effect to other similar situations (Bandura, 1977).

In addition to mastery of experience, vicarious experience is a source of information regarding one's level of self-efficacy, although Bandura (1977) stated this source has less influence compared to personal performance accomplishments. Vicarious experience refers to viewing others perform or model activities without negative consequences, which then generates feelings of persistence and improved personal self-efficacy due to social comparison (Bandura, 1977).

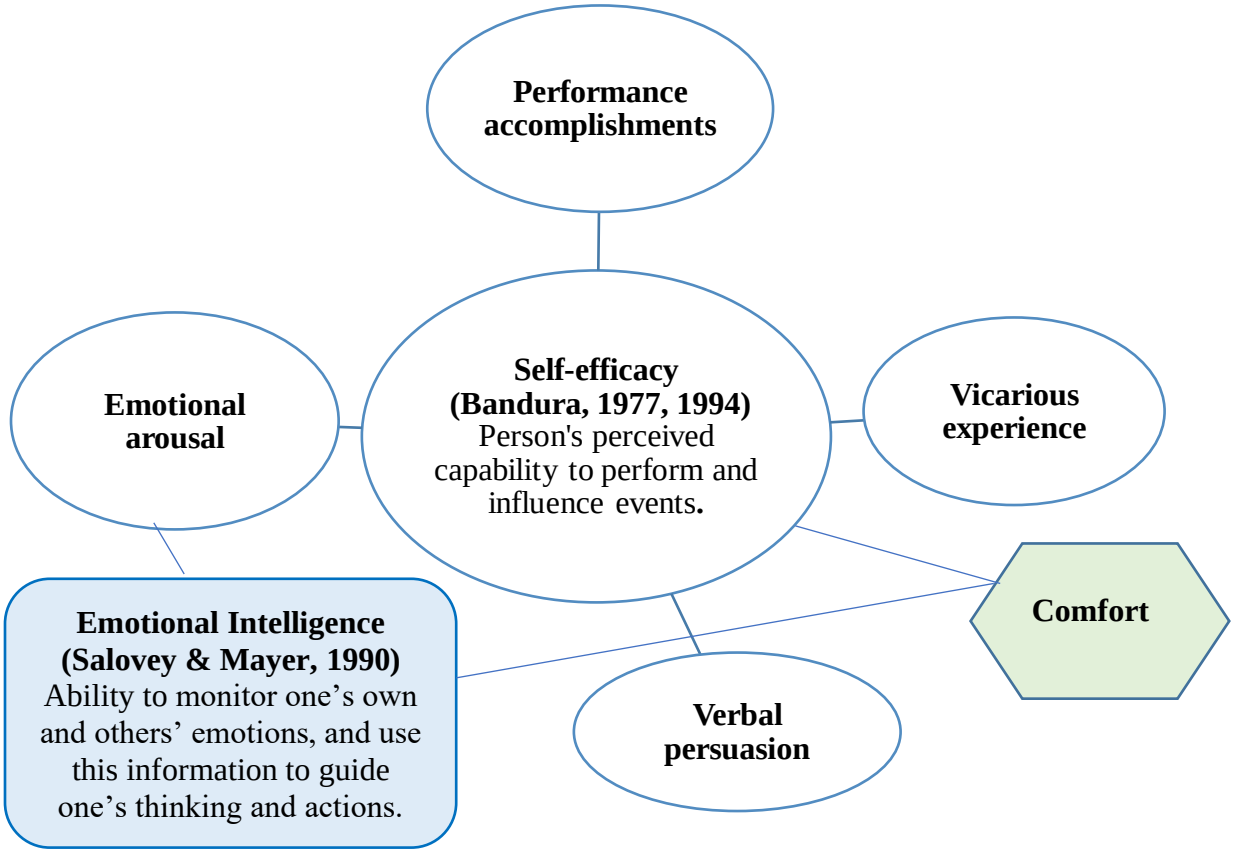
The third source of information to influence human behavior relates to verbal persuasion, through which persons are supported to believe they can cope and manage successfully, regardless of prior feelings (Bandura, 1977). Similar to vicarious experience, Bandura said this source is not as strong as performance accomplishments because of the lack of an authentic experiential situation for the individual.

Finally, emotional arousal can affect perceived self-efficacy when the individual is coping with a stressful situation (Bandura, 1977). Bandura stated this source of information relates to self-assessment of one's state of physiological arousal in relation to anxiety and vulnerability to stress. High emotional arousal often "debilitates performance" and increases avoidance behavior (Bandura, 1977, p. 198). The author said perceived self-efficacy is often associated with less stress, anxiety, and fear-provoking situations. Bandura stated both modeling and, more significantly, experienced mastery can assist to reduce dysfunctional fears and emotional arousal. Fears and deficits are often intertwined. Hence, teaching effective coping

skills and ways to handle stressful situations can reduce anticipatory emotional arousal (Bandura, 1977).

Nursing students develop their perceived capabilities to perform nursing practice in theoretical and clinical settings, often applying these sources of information. Using Bandara's (1977) theoretical framework and connections to Salovey and Mayer's (1990) emotional intelligence definition, this research focused on self-efficacy and emotional intelligence as they relate specifically to fourth year nursing students' comfort in providing palliative and end-of-life care for persons and families. A conceptual map representation of Bandura's definition of self-efficacy (1994), the four sources of efficacy information (1977), and the definition of emotional intelligence (Salovey & Mayer, 1990) are provided in figure 1, as it relates to this study.

Figure 1- Theoretical Framework and Definitions



References: Bandura, 1977; Bandura, 1994; Salovey & Mayer, 1990.

Self-Efficacy

Nursing curricula include both theory and practical courses which are often sequenced and levelled, thereby providing an opportunity for baccalaureate nursing students to grow and develop in their knowledge and perceived abilities to communicate and manage emotional and complex patient-care situations. The theoretical framework related to self-efficacy (Bandura, 1977), as previously described, provides the foundation for this research. To review, self-efficacy relates to one's personal belief in their capability to effectively function in a specific area of nursing practice, such as PEOLC (Adriaansen & van Achterberg, 2004; Bandura, 1977; Phillips, et al., 2011). Self-efficacy is a challenge, as studies report the need for baccalaureate nursing students to master important aspects of providing care, such as communication on death and dying with persons and families during the end-of-life process (Josephsen & Martz, 2014; White & Coyne, 2011).

Increased self-efficacy is linked to student success in academic studies and in practice (Bandura, 1977; Sook & Kyung, 2019). Self-efficacy is also linked to emotional intelligence competencies which encompass a student's ability to appraise, regulate, respond, and utilize emotional content to effectively problem solve and guide actions (Mayer & Salovey, 1993). Sook and Kyung's (2019) study supports these linkages, pointing out that the use of emotion and regulation of emotion had direct effects on self-efficacy and the clinical performance of senior baccalaureate nursing students. Their research "results suggest that self-efficacy acts as a driving force enabling nursing students to perform a given role effectively and as a major factor in increasing their clinical performance" (Sook & Kyung, 2019, p. 386). Dunn et al. (2014) have also suggested that the self-efficacy of the nurse influences the quality of patient care they provide. Graduating nursing students need to believe that they have the capability to perform the required behavior and that their PEOLC actions will result in quality care (Phillips et al., 2011).

Emotional Intelligence

In addition to perceived ability to acquire and apply knowledge, baccalaureate nurses need to possess self-awareness and be able to manage their emotions and emotional responses when communicating and providing PEOLC with persons and their families. During the early 1980s, the traditional understanding of the term intelligence was challenged by Gardner's theory of multiple intelligences (Gardner, 2006). Gardner proposed a multifaceted view in which he described independent intelligences: musical intelligence; body-kinesthetic intelligence; logical-mathematical intelligence; linguistic intelligence; spatial intelligence; interpersonal intelligence; and intrapersonal intelligence. Later, the theory was expanded to include naturalistic intelligence, which encompasses the world of nature and natural surroundings, and existential intelligence, which helps a person to inquire and seek answers to deeper questions about life and human existence (Gardner, 2000; Gardner, 2006).

Payne's (1985) doctoral dissertation work on emotion introduced and discussed the term emotional intelligence (Bradberry & Su, 2006). Payne described a stimulating event, followed by evaluation and then response, which includes emotional, physical, intellectual, and visual aspects of consciousness, as the sequence of events leading to an emotion. Payne (1985) further explained how a paradigm shift is associated with a change in how a person perceives, interprets, and experiences a real situation.

Salovey and Mayer (1990) provided a definition and a framework for emotional intelligence. The authors reported that emotions often occur as a response to an external or internal event, resulting in a negative or positive meaning for the individual. They defined emotional intelligence as "the ability to monitor one's own and others' feelings and emotions, to discriminate among them, and to use this information to guide one's thinking and actions" (Salovey & Mayer, 1990, p. 189). Salovey and Mayer connected the definition of emotional

intelligence with the interpersonal and intrapersonal multiple intelligences described previously by Gardner. Interestingly, demonstrating empathy and having the ability to use emotions in ways to increase creative thinking, adaptive planning, and problem-solving to improve outcomes was highlighted (Salovey & Mayer, 1990). Both empathy and using emotions in ways to increase creative thinking, adaptive planning, and problem solving are important in the role of the baccalaureate nurse when providing safe and effective nursing care to patients and families (College of Nurses of Ontario, 2019; The Standard, College of Nurses of Ontario, 2020).

Goleman's (2005) work on emotional intelligence detailed the biological responses when acting on an emotion can be shaped by personal life experiences and culture. Goleman reinforced how the emotional and the rational mind often work in harmony, guiding daily personal and work life as they connect the different ways of knowing. This idea relates to the notion that, emotional intelligence is distinct and yet complementary to academic intelligence (Goleman, 2005; Kelly & Quesnelle, 2016). During significant emotional events, Goleman stated the emotional mind often has a stronger effect and influences one's actions. The author provided a framework in which the fundamentals of emotional intelligence including self-awareness, social awareness, self-management, and the ability to manage relationships are related to on-the-job success (Goleman, 2005). Building on this idea, emotional intelligence relates to the person's potential to learn the fundamentals of self-mastery, ability to apply relevant competencies, and effectively perform on the job (Goleman, 2005).

A correlational study which examined self-efficacy and emotional intelligence as predictors for successful clinical performance in nursing students was conducted by Rice (2015). Bandura's self-efficacy theoretical framework, as well as Mayer and Salovey's theory of emotional intelligence were applied conceptually in the study by Rice. Using the Mayer-Salovey-Caruso Emotional Intelligence Test (MSCEIT) and the Self-efficacy in Clinical

Performance Scale, the study results identified that higher emotional intelligence was positively correlated with clinical self-efficacy (Rice, 2015).

Based on a review of the literature, Harrison and Fopma-Loy (2010) identified assumptions concerning emotional intelligence in that it is an essential component of nursing practice. Harrison and Fopma-Loy suggested the abilities linked to emotional intelligence can be learned and developed via various teaching strategies to promote emotional competence. The authors used Goleman, Boyatzis, and McKee's (2002) emotional intelligence framework, incorporating the four domains of self-awareness, social awareness, self-management, and relationship management, as a basis to create ten progressive, guided journal prompts as a teaching strategy (as cited in Harrison & Fopma-Loy, 2010). Students (n = 16) enrolled in two clinical groups responded to one prompt in their writing each week, with prompt 10 being a meta-reflection on all previous responses (Harrison & Fopma-Loy, 2010). Harrison and Fopma-Loy suggested that students can develop self-awareness and emotional competencies through learning opportunities involving reflection. The findings identified that integrating progressive journal prompts is a useful strategy to stimulate awareness and reflection on emotional intelligence competencies (Harrison & Fopma-Loy, 2010).

Using Bandura's self-efficacy theory framework, Sook and Kyung's (2019) study examined the variables involving emotional intelligence (self-emotional appraisal, other's emotional appraisal, use of emotion, regulation of emotion), problem-solving ability, self-efficacy, and clinical performance. The study results supported the idea that nursing students having high emotional intelligence "increases their self-efficacy and problem-solving ability, and high self-efficacy and problem- solving ability enhance clinical performance, which improves nursing quality" (Sook & Kyung, 2019, p. 386).

Perceptions of an emotional event (Payne, 1985) and the resulting attitudes of the nurse can also impact the response and clinical performance of the nursing student. Aradilla-Herrero et al. (2012) analyzed the relationships between death attitudes and perceptions of emotional intelligence among Spanish undergraduate nursing students, across three years in a nursing degree program. Using Salovey and Mayer's (1990) definition of emotional intelligence, the aim was to assist nursing students to cope with emotionally stressful situations and to highlight the importance of nurses being taught strategies to manage their emotions and to learn social and communication skills (Aradilla-Herrero et al., 2012). In this study, the authors found that third-year nursing students obtained higher scores than first-year students on the three dimensions (attention to feelings, clarity of feelings, and mood repair) of emotional intelligence. Also, students having an increased understanding and management of emotions were also found to experience lower levels of fear of death (Aradilla-Herrero et al., 2012). Fear of death and dying may result in a person experiencing uncomfortable emotions. As such, it is important to examine the research on emotional intelligence and comfort of nursing students when providing PEOLC.

Comfort

Senior baccalaureate student nurses may have little to no experience witnessing death or caring for patients and families during end-of-life. Given this, they may feel fearful, experience stress-related emotions and have little confidence when assigned as care providers of dying patients and their families (Carvalho et al., 2020; Corcoran, 2016). Colley (2016) reinforced that nursing education preparation for senior students must focus on end-of-life care in which a foundational level of confidence and comfort is developed as they start their profession. The author proposed that the topic of end-of-life is often avoided due to various factors such as the younger age of nursing students, their perceptions of the nursing profession as centered around healing, and the fact that discussing death and dying can be very difficult (Colley, 2016).

Providing quality palliative and end-of-life care is essential during all stages of the life span. O'Shea et al. (2017) emphasized this point by studying the educational needs of pediatric healthcare professionals. The End-of-Life Professional Caregiver Survey (Lazenby et al., 2012) was used by O'Shea et al. to assess the educational needs of participants involved with caring for children having complex medical or life-threating conditions. The authors wrote that 52.1% of the participants were registered nurses (RN) or advanced practice registered nurses (APRN). Results of the study pointed to the "need for formalized palliative care education integration into health care provider curricula" (O'Shea et al., 2017, p. 471). O'Shea et al. also supported the importance of continued and ongoing PEOLC education programs for healthcare professionals practicing in pediatric settings.

Corcoran's (2016) study emphasized the need for education programs to improve nurses' comfort levels when communicating with patients and their families and providing end-of-life care. Comparing mean pre-test and mean post-test scores of nursing professional caregivers, based on the End-of-Life Professional Caregiver Survey (Lazenby et al., 2012), a significant difference was identified, signifying that an education workshop intervention was effective in improving nurses' comfort levels with providing end-of-life care (Corcoran, 2016).

Medical Assistance in Dying (MAID)

Lack of comfort or feeling unprepared can also surface when there are ongoing changes in legislation associated with PEOLC, which can have an impact on clinical practice and the care provided by nurses. One such example is the legislation of Bill C-14, in which medical assistance in dying or MAID became legal in Canada in June 2016 (Ontario Ministry of Health and Long-Term Care, 2023). This federal legislation outlined the eligibility criteria for individuals wanting to apply for MAID and established the safeguards for a physician or nurse

practitioner to follow to legally provide medical assistance in dying (Ontario Ministry of Health and Long-Term Care, 2023).

The federal government passed An Act to Amend the Criminal Code (Medical assistance in dying), referred to as Bill C-7, on March 17, 2021 (Ontario Ministry of Health and Long-Term Care, 2023). This bill outlined amendments such as additional data collection and expanded eligibility criteria "to include persons whose natural death is not reasonably foreseeable; established a separate set of safeguards for individuals whose natural death is not reasonably foreseeable; and made amendments to the safeguards for individuals whose natural death is reasonably foreseeable" (Ontario Ministry of Health and Long-Term Care, 2023, p. 2). The Department of Justice Canada provided a news release in February 2023 and "introduced legislation to extend the temporary exclusion of eligibility for MAID where a person's sole medical condition is a mental illness until March 17, 2024" (Government of Canada, 2023, p. 2). The proposed extension is to provide additional time to review the Special Joint Committee on MAID's final report and to prepare for the safe and consistent assessment and provision of MAID in these circumstances (Government of Canada, 2023).

Canadian patients inquiring about the process for MAID will often speak with their physician or primary care provider, such as a registered nurse (RN). The RN, although not administering or counselling in regards to MAID, may perform other duties such as preparing intravenous access and equipment, providing care following death, and supporting the patient and their loved ones (Pesut et al., 2020). Registered nurses can refer to their respective governing body, for example, the College of Nurses of Ontario (2023), for information on medical assistance in dying as it relates to their professional role and responsibilities. If a conflict with a nurse's moral or religious beliefs is anticipated but is within professional practice, it is the nurse's responsibility to notify their employer and to provide continued quality care until

alternate care arrangements can be made (Canadian Nurses Association, 2017). The legislation on medical assistance in dying (MAID) and associated ongoing amendments have had a significant impact on nursing education and nursing practice within the context of MAID (College of Nurses of Ontario, 2023; Pesut et al., 2019). The College of Nurses of Ontario's (2019) most recent entry to practice competencies outlines how graduate registered nurses are to incorporate knowledge about the ethical, legal, and regulatory implications of medical assistance in dying (MAID) when providing nursing care. Policy, practice, and ethical implications need to be addressed in nursing education (Pesut et al., 2019) in an effort to prepare nursing graduates to provide quality PEOLC, promote self-care, and manage nursing practice situations involving MAID.

Promoting self-care is an important aspect of the nursing profession, as the emotional impact, especially when providing PEOLC care, can have an influence at a personal level and can also influence one's ability to safely practice and provide effective care to patients and their families (College of Nurses of Ontario, 2020). Guiding questions for reflection, personal strategies and organizational strategies can be implemented to assist with and promote self-care for registered nurses (College of Nurses of Ontario, 2020).

Covid-19 Pandemic

The Covid-19 pandemic has brought to the forefront the importance of PEOLC in meeting the physical, psychological, social, cultural, and spiritual needs of patients and their families. It has also increased awareness of the emotional impact of death and dying in nursing practice and highlighted the need for self-care amongst nursing students and healthcare workers (College of Nurses of Ontario, 2020). During the Covid-19 pandemic, increased exposure to death and dying, and new ethical dilemmas involving end-of-life care have surfaced (Wilson & Chan, 2022). The significant influx of patients admitted to hospitals and intensive care units

(ICUs) raised ethical concerns involving triage, withdrawal of life support decisions, and the separation of seriously ill patients from their loved ones (Robert et al., 2020). Healthcare providers experienced extended workloads, potential shortages of required resources, the fear of transmitting the disease to their own family members, and concerns about potential poor outcomes of their patients (Robert et al., 2020). Wilson and Chan (2022) reinforced that the pandemic was an important 'wake-up call' for all nurses to be prepared and confident to provide PEOLC. Hence, it is essential undergraduate nursing programs strengthen the educational preparation to supervise and support all nursing students, thereby ensuring they have practical palliative and end-of-life experience prior to graduation (Canadian Association of Schools of Nursing, 2020; Wilson & Chan, 2022).

Nursing Education on PEOLC

During the Covid-19 pandemic nursing education programs were forced to modify their curriculum by moving courses online, by limiting student access to visit onsite campus resources, and by arranging alternate learning opportunities to replace cancelled in-person clinical placements (Lee, 2022a). Prior to the pandemic, there were challenges identified concerning nurses receiving adequate education and practice opportunities related to palliative and end-of-life care in their undergraduate curricula (Cavaye & Watts, 2014; Corcoran, 2016; Fabro et al, 2014; Gillan et al., 2014). Though, the role of the nurse graduate is to provide safe, quality, and holistic care to persons throughout the lifespan in diverse clinical settings (Cavaye & Watts, 2014; Corcoran, 2016; Fabro et al, 2014; Gillan et al., 2014). With ongoing changes not only within society but also within the nursing profession, ensuring that student nurses have the required competencies and comfort to provide palliative and end-of-life care to persons in all healthcare settings is essential (Rietze et al., 2018; White & Coyne, 2011).

From a program perspective, Rietze et al. (2018) discussed how the accreditation process has shifted to competency statements for evaluation of the learning outcomes and nursing curriculum. This shift is evident in the entry-to-practice competency statements for registered nurses and the new nursing education program approval process with the College of Nurses of Ontario (CNO, 2019; CNO, 2022a). The following list provides some examples of entry to practice competency statements (CNO, 2019) relevant to PEOLC in nursing education:

1.1 Provides safe, ethical, competent, compassionate, client-centred and evidence informed nursing care across the lifespan in response to client needs.

1.9 Recognizes and responds immediately when client's condition is deteriorating.

1.12 Implements evidence-informed practices of pain prevention, manages client's pain, and provides comfort through pharmacological and non-pharmacological interventions.

1.14 Provides nursing care to meet palliative and end-of-life care needs.

1.15 Incorporates knowledge about ethical, legal, and regulatory implications of medical assistance in dying (MAID) when providing nursing care.

1.26 Adapts practice in response to the spiritual beliefs and cultural practices of clients.

2.7 Identifies and addresses ethical (moral) issues using ethical reasoning, seeking support when necessary.

3.3 Uses evidence-informed communication skills to build trusting, compassionate, and therapeutic relationships with clients.

3.7 Communicates effectively in complex and rapidly changing situations.

4.2 Initiates collaboration to support care planning and safe, continuous transitions from one health care facility to another, or to residential, community or home and self-care.

5.1 Consults with clients and health care team members to make ongoing adjustments required by changes in the availability of services or client health status.

7.10 Advocates for client's rights and ensures informed consent, guided by legislation, practice standards, and ethics.

7.13 Demonstrates knowledge of a substitute decision maker's role in providing informed consent and decision-making for client care (College of Nurses of Ontario, 2019).

When considering the relevant competencies and attributes associated with this area of practice, reviewing the literature describing the lack of end-of-life education and training in undergraduate nursing curricula is important (Carvalho et al., 2020; Gillian et al., 2014; Lippe et al., 2017). Nurse educators and instructors who have a lack of knowledge as well as a lack of experience in PEOLC have been described as possible reasons for this deficiency (Lippe et al., 2017). Josephsen and Martz (2014) reported how faculty identified the barriers associated with EOL nursing education as limited class time (Hold et al., 2014) and large class sizes, the level of faculty knowledge and discomfort with the content, and the assumption the theory was too complex to be taught in an undergraduate program. While the theory and concepts related to PEOLC are often complex and have emotion-laden associations, this researcher believes this is not a valid rationale for nurse educators to minimize or to avoid incorporating educational and practice learning opportunities into their teaching.

Colley (2016) identified that nurse educators may believe that nurses will learn about end-of-life care while working in the profession and through ongoing experiences. There also may be an assumption that PEOLC theory and experiences are provided within the student clinical placement settings although nursing students may not have had an opportunity to provide care for persons and their families during end-of-life (Fabro et al., 2014). An additional contributing factor relates to work by Gillan et al. (2014) reporting that "there is little content on end-of-life care in undergraduate nursing textbooks" (p. 331). Colley (2016) supported this claim and stated that end-of-life care content in texts is "rudimentary and student exposure to the psychosocial

aspects of dying is inadequate" (p. 279). In addition, Rietze et al. (2018) reaffirmed that a lack of faculty with PEOLC knowledge was a barrier, as well as overcrowded curricula and curricular drift. Similarly, nurse educators reported that there was no room to expand the theory on PEOLC because the curriculum was already full (Lippe et al., 2017).

The use of simulation in nursing programs is supported in the literature as an additional strategy to address some of the education issues identified. Fabro et al. (2014) suggested high-fidelity end-of-life simulation provides a safe, interactive, and effective learning environment for baccalaureate nursing students. The authors supported integrating end-of-life simulations within the curricula enhances achievement of specific learning outcomes related to therapeutic communication, collaboration, and management of care. In addition, Fabro et al. stated that the use of simulation provides an opportunity for nursing students to apply the principles of palliative care, as well as increase their comfort and confidence in caring for dying patients and their families. Correspondingly, simulation learning provided an opportunity for nursing students to reflect and analyze their personal feelings and responses to death and dying (Fabro et al., 2014; Kunkel et al., 2016).

It is imperative that nursing students have the opportunities and the time to reflect and analyze their emotions, actions, and attitudes towards death and dying. A study by Dame and Hoebeke (2016) used Mezirow's transformational learning theory and the survey instrument Frommelt Attitudes Toward Care of the Dying Scale-Form B (FATCOD-B) to measure nursing students attitudes related to an end-of-life care simulation. Dame and Hoebeke said student participants reported increased confidence in assessing physical and psychosocial needs, providing comfort care, and communicating with a dying patient and the family following the simulation. Integration of simulation in the curricula as a learning strategy to enhance nursing

students' knowledge and attitudes toward end-of-life care for patients and their families was recommended (Dame & Hoebeke, 2016).

Similarly, a study completed by Dunn et al. (2014) examined the use of high-fidelity simulation and the influence on baccalaureate nursing students' self-efficacy concerning patient communication and physical care, using the Nursing Student Self-Efficacy Scale (NSSES). Dunn et al. found the results supported the assumption that simulation training may be a useful strategy to increase nursing students' efficacy concerning patient communication and physical patient care, both of which are critical in providing quality palliative and end-of-life care to patients and their families.

The theoretical framework used in this study was described, followed by review of the research associated with the following variables: self-efficacy, emotional intelligence, and comfort involving nursing students providing PEOLC for patients and families. In addition, a review of the literature and legislation on medical assistance in dying (MAID), the impact of the Covid-19 pandemic, and research on nursing education concerning PEOLC was conducted as each area relates to the purpose of this research study.

Chapter 3- Methodology

Research Design

This study used a mixed methods research design, selected to generate understanding of the research problem (Creswell, 2008). A sequential explanatory design (Appendix A) in which cross-sectional, correlational research involving quantitative data collection and analysis in the first phase, followed by qualitative data collection and analysis (Creswell, 2008; Polit & Beck, 2017) was used in the study. It is important to keep in mind that relationship among variables, rather than causality, is the goal of correlational research (Polit & Beck, 2017).

The strength of a sequential explanatory design is its potential to further interpret and explain quantitative results by follow-up collection and analysis of qualitative data (Creswell, 2009). In addition, the straightforwardness of the design with separate stages provides an opportunity for clear description and reporting in which the two forms of data are separate, yet connected (Creswell, 2009). The integration of the findings was then summarized using a narrative approach (Polit & Beck, 2017). The analysis of quantitative data focused on the relationship of self-efficacy and emotional intelligence with fourth-year baccalaureate nursing students' comfort in providing palliative and end-of-life care was followed by analysis of qualitative findings in the second phase. The design "captures the best of both quantitative and qualitative data" (Creswell, 2008, p. 560).

Ethical Review

Ethics approval from the Ethics Review Board (ERB) was obtained on June 15, 2021 from the University Institutional Review Board, prior data collection. As previously discussed, an email was forwarded to the Nursing Undergraduate Program Director (Collaborative Program) and the President of the Nursing Student Association in which the participation invitation letter (Appendix B) was distributed to the fourth-year baccalaureate nursing students at

the University. The email was sent out three times as reminders in November and December 2021. In addition, this researcher left two voice messages with the Nursing Undergraduate Program Director to discuss possible strategies for research participation during the events of the Covid-19 pandemic lockdown. Participants indicating interest in the second phase of the study were contacted via email and two Zoom meetings were scheduled, one on January 29, 2022 and the second on January 30, 2022.

Informed consents (Appendix C and D) were obtained from all fourth-year nursing student participants. Estimated time commitments were provided on the research participant informed consent forms, in addition to a statement on the security limitations of using online platforms. Participants were also informed that their decision to participate in the study would not affect their student status. Privacy and confidentiality of participants was maintained throughout the research study.

Data Collection- Quantitative

Given the explanatory mixed methods design of this study, quantitative data was collected first with a stronger priority, followed by qualitative data collection (Creswell, 2008; Creswell, 2009). A convenience sample of fourth-year baccalaureate nursing students at a large urban University was invited to participate in the quantitative data collection phase of the study following email distribution of the participation invitation letter. It was this researcher's understanding that the sampling frame was approximately 400 fourth-year university nursing students, with the goal of n = 30 or more, as Creswell (2008) reported this is adequate for a correlational study. An email was forwarded to the Nursing Undergraduate Program Director (Collaborative Program) and the Nursing Student Association president in which the participation invitation letter was distributed to fourth-year baccalaureate nursing students at the university. Three email reminders were sent out at different times in November and December

2021 to enhance participation rates. In addition, this researcher left two voice messages with the Nursing Undergraduate Program Director to discuss possible strategies to increase sample size during the Covid-19 pandemic. Also, in response to the pandemic there was a university lockdown and changes were required concerning research activities. As such, the urban university Qualtrics survey tool was used for collecting the survey data from consenting participants, rather than meeting face-to-face with the fourth-year nursing students. The first phase involved completion of three validated instruments, followed by collection of the participant demographic data via a self-report questionnaire (Appendix E).

The first instrument (Appendix F) was the Palliative Care Self-Efficacy Scale (Phillips et al., 2011). This 12-item instrument was taken from a Palliative Care Provider evaluation tool, which was included in a compendium of tools to assist in the evaluation of palliative care projects (Eagar et al., 2003; Phillips et al., 2011). The 12-item instrument has two distinct theoretical subscales, specifically, psycho-social support (Items 1 to 6) and symptom management (Items 7 to 12), by which participants are asked to rate their perceived self-efficacy to manage these aspects of end-of-life care (Phillips et al., 2011). The authors reported that the instrument has a four-point grading scale: needing further basic instruction; confident to perform with close supervision/ coaching; confident to perform with minimal consultation; and confident to perform independently. The person's belief in their self-efficacy impacts their feelings, thinking, and motivation resulting in action (Bandura, 1994). The study investigated the psychometric properties of the 12-items and determined that the instrument is valid and reliable with strong internal consistency, having a Cronbach's alpha of 0.92 (Phillips et al., 2011). The authors identified the specific advantages to the instrument are its brevity and simplicity, as well as its distinctions between educational levels which can have an influence on educational

preparation and competencies related to clinical practice. Recommendations included further use and evaluation of the instrument among professional groups is warranted when considering the importance of improving palliative health care outcomes (Phillips et al., 2011).

The second instrument (Appendix G) was entitled End-of-Life Professional Caregiver Survey or EPCS (Corcoran, 2016; Gannon et al., 2017; Lazenby et al., 2012). The EPCS was developed to assess the educational needs of health care professionals concerning palliative and end-of-life care (Lazenby et al., 2012). The study by Lazenby et al. involved 369 inter-professional participants, specifically nurses, physicians, and social workers, with the α of 0.96. The 28-item survey uses a 5-point Likert scale (ranging from 0 = not-at-all to 4 = very much), and breaks down as follows: 12-items on Patient and Family-Centered Communication (α = 0.95), 8-items on Cultural and Ethical Values (α = 0.89), and 8-items on Effective Care Delivery (α = 0.87) (Lazenby et al., 2012). An example item on comfort is question number one, 'I am comfortable helping families to accept a poor prognosis.' For the purpose of this research, question number 26 was adjusted slightly from 'I feel confident addressing requests for assisted suicide', to 'I feel comfortable addressing requests for medical assistance in dying (MAID)', thereby representing the recent federal legislative changes and graduate registered nurse competencies.

The third instrument (Appendix H) was the 33-Item Emotional Intelligence Scale (Schutte et al., 1998). The items represent Salovey and Mayer's (1990) emotional intelligence conceptual model and, specifically, three categories involving appraisal and expression of emotion, regulation of emotion, and utilization of emotions in solving problems (Schutte et al., 1998). Although, there was no identification of the specific questionnaire items that aligned with the three categories. The survey uses a 5-point Likert scale (ranging from 1 = Strongly Disagree

to 5 = Strongly Agree), and has a Cronbach's alpha of 0.90 (Schutte et al., 1998). Stenhouse et al.'s (2016) study also used the scale in the setting of adult and mental health nursing and midwifery programs and described the internal consistency by Cronbach's alpha of 0.858. Schutte et al. (1998) reported good internal reliability using two different samples and stated that the two-week test-retest reliability was 0.78.

The instruments used to measure the key variables, self-efficacy, comfort, and emotional intelligence for the quantitative phase included: The Palliative Care Self-Efficacy Scale, n = 12, (Phillips et al., 2011); The End-of-Life Professional Caregiver Survey, n = 11, (Lazenby et al., 2012.); the 33-Item Emotional Intelligence Scale, n = 9, (Schutte et al., 1998), thereby generating a total of 749 item-specific data results. All instruments were freely available online and credit was given to the sources.

Data Collection- Qualitative

The focus of the second phase of this study was to further interpret and understand quantitative results by follow-up collection and analysis of qualitative data (Creswell, 2009). The goal of the qualitative data collection was to glean an account of the phenomenon and description of the lived experiences told from the point of view of fourth-year baccalaureate nursing students regarding self-efficacy, emotional intelligence, and comfort in providing palliative and end-of-life care for persons and families (Creswell, 2009; Gaudet & Robert, 2018). The methodological approach was to interpret the lived experience of the phenomenon as described by the participants (Gaudet & Robert, 2018). One of the premises of phenomenology is "the focus on the lived experience" (Gaudet & Robert, 2018, p. 43). The thematic analysis process by Gaudet and Robert (2018) was used to identify themes during the qualitative data analysis phase. Parse's (1990; 2008) research method was also influential during the qualitative

phase of this study in which the nursing student participants described personal circumstances and particular student nursing experiences when engaged in dialogue with this researcher.

Recommendations for the number of participants in the qualitative data collection phase ranged from two to ten (Parse, 1990), four to six (Creswell, 2008), and six to eight (LoBiondo-Wood et al., 2018). Originally, qualitative data collection using a focus group was planned. However, in response to the university lockdown and required changes to research activities because of the Covid-19 pandemic the videoconferencing and collaboration tool, Zoom, was used for collecting the qualitative data remotely. Based on the initial number of fourth-year nursing students who had expressed interest in participating in this research study, two focus groups having five participants in each were scheduled on separate days. Though, for each focus group arranged, only one participant attended each day. No emails were received from any of the nursing students communicating the reason for their absence.

The timing when collecting the qualitative data on January 29, 2022 and January 30, 2022 coincided with the sudden political and social unrest involving the trucker convoy in Ottawa, and the obstruction of access to a few major Canada-United States border crossings by trucker protest blockades. This unprecedented and disturbing historical event in which demonstrators were protesting covid-related restrictions may have impacted the nursing student participation rate. A higher participation rate was anticipated. In-depth dialogues in which the lived experiences (Parse, 1990) of two fourth-year nursing students were conducted during the second phase of this mixed methods research study.

Parse (1990), nursing theorist and researcher, contends that two to ten participants is adequate when the participants are able to describe the lived experience “when engaged in dialogue with the researcher” (p. 10) and when there is a repeated pattern of engagement. The theorist and researcher stated, “The descriptions are the evidence, the truth for the moment about

the phenomenon; they are testimony to personal circumstances" (Parse, 2008, p. 46). Correspondingly, the concept of information power (Malterud et al., 2016; Vasileiou et al., 2018) was also considered concerning sample size in this research study. The concept of information power suggests the more information provided by the sample regarding the phenomenon being studied, the lower number of participants is needed (Malterud et al, 2016; Vasileiou et al., 2018). The specific aim of the study, specific experiences of the sample, using an established theory, and the quality of the dialogue are also important considerations (Malterud et al., 2016). All of these factors were relevant and applicable to qualitative data collection within this study.

During the in-depth dialogue with two fourth-year nursing students, six open-ended questions (Appendix I) were posed. There is a challenge in obtaining up-front ethical approval for the second phase of the study involving qualitative data collection when the results of the first phase are unknown (Polit & Beck, 2017). This factor was also a consideration in relation to the barriers associated with the research processes during the pandemic. As such, for ethical approval the open-ended questions were developed prior in relation to the research question, research variables, and relevant literature. This approach continued to provide an opportunity for the second phase to further expand upon and gain an increased understanding (Creswell, 2008**),** in which the qualitative data "builds on the results of the initial quantitative results" (Creswell, 2009, p. 211).

The first three questions explored the perspectives of fourth-year baccalaureate nursing students on their emotional responses, self-efficacy, and comfort in providing PEOLC to persons and their families. The final three questions were derived to gain a greater understanding of the participant's previous experiences, comfort concerning medical assistance in dying (MAID), and viewpoints on nursing education regarding PEOLC. The six qualitative questions were previously approved at the time of this researcher's proposal defense and by the ethics review

board. Participants were encouraged to freely share and describe their individual lived experiences, and probes were used on a few occasions to gain further understanding (Parse, 1990; Singh & Thirsk, 2022). A Philips audio recorder and Zoom were used to record the discussions. Following the individual dialogues, this researcher completed the post interview field notes (Appendix J) and detailed transcriptions.

Data Analysis- Quantitative

SPSS software 28 was used to analyze the quantitative data. A total of 749 item-specific data results were generated from the three surveys. Descriptive statistics, including frequencies and percentages, were used to summarize the student demographic data. Scores and mean scores for the three survey instruments were displayed visually using tables. The correlation coefficients for the variables in the study were displayed using a correlation matrix (Creswell, 2008). The correlation co-efficient, also called Pearson's r, provides important information about the direction and magnitude of a relationship between two variables (Polit & Beck, 2017). Following the creation of the table scores and correlation matrix, scatter plots related to the research questions were created. In addition, reliability analysis using Cronbach's alpha (Singh & Thirsk, 2022) was conducted, with data being presented for each of the three instruments used in the study.

An advantage that Singh and Thirsk (2022) have identified for a correlational study is the "increased flexibility when investigating complex relationships among variables" (p. 253). This is relevant when studying the relationships and variables involving palliative and end-of-life care, as this area of practice is often complex and difficult to manipulate. A second strength of a correlational study is its efficiency and the volume of data that can be collected about a problem (Polit & Beck, 2017). Further, in this research, the rationale for a correlational study was to quantify the strength of association or relationship between two variables at a specific point in

time involving fourth-year baccalaureate nursing students' comfort with providing palliative and end-of-life care (Creswell, 2008; Polit & Beck, 2017; Singh & Thirsk, 2022).

Data Analysis- Qualitative

Qualitative data was analyzed using thematic data analysis involving vertical analysis, semantic condensation, and horizontal analysis (Gaudet & Robert, 2018). Gaudet and Robert stated the first stage of vertical analysis involved reading the interview questions and transcripts multiple times in order to condense and summarize the material. During semantic condensation, the material was reduced based on meanings related to the research question (Gaudet & Robert, 2018). The rigour of condensation and validity of the research results, as per Gaudet and Robert, was demonstrated by providing clear definitions (Appendix K) of meanings and the categorizations created. Next, horizontal analysis involved linking the analytical threads and connecting the categories to the research question to gain a greater understanding of the phenomenon being studied (Gaudet & Robert, 2018). A conceptual map was generated to assist with interpreting the themes and sub-themes when reporting the analysis process and results (Vaismoradi et al., 2013).

Findings from the two separate quantitative and qualitative data analyses were compared and integrated in an effort to "develop an overall interpretation" (Polit & Beck, 2017, p. 591). The integration of these findings is summarized using a narrative approach and is included in the data integration and summary of findings section (Polit & Beck, 2017).

Chapter 4- Research Results

In this chapter, a review of the context in which this research study was conducted is described. The quantitative and qualitative research results are provided separately, followed by a summary of the integration of the quantitative and qualitative findings using a narrative approach (Polit & Beck, 2017).

Context

The impact of the Covid-19 pandemic on nursing education, nursing students, and the challenges faced by graduate researchers (Flaherty, 2021; Ramos, 2021) has been significant. Nursing education programs were forced to modify their curriculum by moving courses online, by limiting student access to visit onsite campus resources, and by arranging alternate learning opportunities to replace cancelled in-person clinical placements (Lee, 2022a). Nursing students reported increased stress and anxiety associated with adapting to new learning environments, concern regarding successful completion of the program, lack of clinical experiences, as well as fear of infection and the well-being of family members (Joseph et al., 2022). Similarly, graduate researchers experienced increased anxiety and barriers associated with adapting to new research processes, such as having to shift to remote research, and concerns regarding data collection and successful completion of research projects (Flaherty, 2021; Levine et al., 2021; Ramos, 2021; Sutherland et al., n.d.). The pandemic also caused individual, social, and political unrest as unprecedented countrywide lockdowns and protests occurred.

Results of the Study- Quantitative

Quantitative data was collected in the first phase using the demographic data questionnaire and the following three instruments: The Palliative Care Self-Efficacy Scale (Phillips et al., 2011), n = 12; the End-of-Life Professional Caregiver Survey (Lazenby et al., 2012), n = 11; the 33-Item Emotional Intelligence Scale (Schutte et al., 1998), n = 9. The three

instruments yielded 749 item-specific data results. The following paragraphs and tables outline the quantitative results of this study.

Demographic Data

The population of interest for this study involved fourth-year baccalaureate nursing students enrolled in a large urban university. Descriptive statistics, including frequencies and percentages, were used to summarize the student demographic data (Table 1). The demographic data was collected last, following the three survey instruments, with a total of nine (9) participants completing this component. The age of the participants ranged from 21 to 27, with the majority age of participants in the 21 to 22 age range. All participants identified as being in the fourth and final year of the baccalaureate nursing program with the majority reporting they were female gender.

Just under half of the participants identified themselves as a spiritual and religious person. All participants reported covering palliative and end-of-life care in at least one of the following: core courses, an elective, or in other courses. Just under half of the nursing students reported having previous experience with end-of-life involving a pet, slightly over half reported providing palliative and end-of-life care for a terminally ill family member, loved one, or friend, and slightly over three quarters of the participants indicated having experience providing palliative and end-of-life care for an assigned patient as a student or healthcare worker. All nursing students completing the demographic data reported they did not have any previous experience with persons requesting medical assistance in dying (MAID).

Table 1

Demographic Data of Nursing Student Participants

Variables	Frequency	Percent
Gender		
Female	7	77.8
Male	2	22.2
Age		
21	4	44.4
22	2	22.2
23	1	11.1
25	1	11.1
27	1	11.1
A spiritual person		
Yes	4	44.4
No	5	55.6
A religious person		
Yes	4	44.4
No	5	55.6
Final Year of BScN Program		
Yes	9	100
No	-	-
Courses/ electives cover PEOLC		
Yes	9	100

Variables	Frequency	Percent
No	-	-
Previous EOL experience: Pet		
Yes	4	44.4
No	5	55.6
Previous EOL experience: Family/ Loved one/ Friend		
Yes	5	55.6
No	4	44.4
Previous EOL experience: Nursing student/ HC Worker		
Yes	7	77.8
No	2	22.2
Previous experience persons requesting MAID		
Yes	-	-
No	9	100

Note. N = 9.

Palliative Care Self-Efficacy Scale

The first instrument used in the research study was the Palliative Care Self-Efficacy Scale (Phillips et al., 2011). The mean score for this instrument completed by the nursing participants, was 29.58 out of a range of 48. The minimum range score was 17 and the maximum range score was 37, with a standard deviation of 6.68 (Table 2).

Table 2

Palliative Care Self-Efficacy Scale Descriptive Statistics

	N	Minimum	Maximum	Mean	Std Deviation
Self-Efficacy	12	17.00	37.00	29.58	6.68
Valid N	12				

The specific items were examined in relation to the highest and lowest mean scores in relation to self-efficacy involving palliative care. The three item questions identified with the highest self-efficacy mean scores involved: 'Reacting to reports of pain from the patient'; 'Reacting to and coping with reports of constipation'; and 'Reacting to and coping with nausea/ vomiting'. In contrast, the four item questions with the lowest self-efficacy mean scores were: 'Answering patient's questions about the dying process'; 'Reacting to and coping with terminal dyspnea'; 'Discussing patient's wishes for after their death'; and 'Reacting to and coping with terminal delirium' (Table 3).

The Palliative Care Self-Efficacy Scale (Phillips et al., 2011) has a 'psycho-social support' subset involving questions 1 to 6 and a 'symptom management' subset involving questions 7 to 12 (Table 3). The highest self-efficacy mean scores were associated with three of the symptom management subset questions, self-efficacy associated with these specific areas of provision of care and nursing practice are relevant and common to several areas of nursing practice. In contrast, the items with the lowest reported self-efficacy scores are from both the psycho-social support and symptom management areas and are very specific to the provision of patient care during the palliative and end-of-life phases.

Table 3

Mean Item Scores of Palliative Care Self-Efficacy Scale

Items	Mean	Std Deviation
Psycho-social support		
1. Answering patient's questions about the dying process.	1.75	.45
2. Supporting the patient or family member when they become upset.	2.42	1.16
3. Informing people of the support services available.	2.67	.78
4. Discussing different environmental options (e.g., hospital, home).	2.58	1.08
5. Discussing patient's wishes for after their death.	2.17	.94
6. Answering queries about the effects of certain medications.	2.75	.62
Symptom management		
7. Reacting to reports of pain from the patient.	3.17	1.03
8. Reacting to and coping with terminal delirium.	2.17	.94
9. Reacting to and coping with terminal dyspnea (breathlessness).	1.92	.67
10. Reacting to and coping with nausea/vomiting.	2.83	.94
11. Reacting to and coping with reports of constipation.	3.00	.74
12. Reacting to and coping with limited patient decision-making capacity.	2.17	1.11

Note. N = 12.

The reliability statistics analysis using Cronbach's alpha score for the first survey used in the research study was .855, indicating strong evidence of the degree of internal consistency of the instrument (Singh & Thirsk, 2022).

End-of-Life Professional Caregiver Survey

The overall mean score of fourth-year baccalaureate nursing student participants' comfort with providing end-of-life care, using the End-of-Life Professional Caregiver Survey (Lazenby et al., 2012) as the second instrument, was 63.82 out of a range of 112, with a standard deviation of 21.83 (Table 4). Individual participant mean scores ranged from a minimum of 31 to a maximum of 90. This data suggests there were varying comfort levels of the nursing student participants in providing palliative and end-of-life care to patients and their families. Given that the standard deviation is a measure of variability and deviation of the scores from the mean, it would suggest there are significant differences in the dispersion of data (Singh & Thirsk, 2022). Although, the coefficient of variation (CV), or the ratio between the standard deviation and the mean (Dr. M. Singh, personal communication, July 15, 2022), was calculated and the value of .34 was not identified as an issue.

Table 4

End-of-Life Professional Caregiver Comfort Descriptive Statistics

	N	Minimum	Maximum	Mean	Std Deviation
Comfort	11	31.00	90.00	63.82	21.83
Valid N	11				

The three item questions with the highest confident mean scores were: 'I am comfortable talking with other health care professionals about the care of dying patients'; 'I am able to document the needs and interventions of my patients'; and 'I am able to be present with dying patients'. The four item questions with the lowest confident mean scores included: 'I am comfortable helping families to accept a poor prognosis'; 'I am comfortable helping to resolve difficult family conflicts about end-of-life care'; 'I can recognize when patients are appropriate

for referral to hospice'; and 'I am familiar with palliative care principles and national guidelines' (Table 5).

There are three subcategories within the End-of-Life Professional Caregiver Survey (Lazenby et al., 2012), with 'Patient and Family Centered Communication' subscale having 12 items, the 'Cultural and Ethical Values' subscale having 8 items, and the 'Effective Care Delivery' subscale having 8 items (Table 5). Two of the three highest comfort mean scores were identified within the 'Patient and Family Centered Communication' subset, and were linked to communicating with healthcare providers and documentation of patient care needs and interventions, both of which are nursing practice competencies carried out in various clinical settings. The third highest comfort mean score was identified within the 'Cultural and Ethical Values' subset, relating to the ethical value of being present with the patient during provision of care.

The four questionnaire items with the lowest confident mean scores were included within the 'Patient and Family Centered Communication' and 'Effective Care Delivery' subsets. Communicating with families to accept a poor prognosis and helping families resolve difficult conflicts about end-of-life care can involve difficult and emotional conversations. In addition, recognizing when patients are appropriate for a referral to hospice and being familiar with palliative care principals and national guidelines are measures to support and ensure 'Effective Care Delivery'.

Table 5

Mean Item Scores of End-of-Life Professional Caregiver Comfort Scale

Items	Mean	Std Deviation
Patient and Family Centered Communication		
1. I am comfortable helping families to accept a poor prognosis.	1.36	1.03
2. I am able to set goals for care with patients and families.	2.27	1.01
3. I am comfortable talking to patients and families about personal choice and self-determination.	2.64	1.12
4. I am comfortable starting and participating in discussions about code status.	2.00	1.26
5. I can assist family members and others through the grieving process.	2.18	1.54
6. I am able to document the needs and interventions of my patients.	3.45	.69
7. I am comfortable talking with other health care professionals about the care of dying patients.	3.73	.47
8. I am comfortable helping to resolve difficult family conflicts about end-of-life care.	1.45	.82
9. I can recognize impending death (physiologic changes).	2.36	1.21
10. I know how to use non-drug therapies in management of patient's symptoms.	2.64	1.21
11. I am able to address patient's and family members' fears of getting addicted to pain medications.	2.18	1.25

Items	Mean	Std Deviation
12. I encourage patients and families to complete advance care planning.	1.91	1.30
Cultural and Ethical Values		
13. I am comfortable dealing with ethical issues related to end-of-life/ hospice/ palliative care.	2.64	1.29
14. I am able to deal with my feelings related to working with dying patients.	3.18	.98
15. I am able to be present with dying patients.	3.27	1.10
16. I can address spiritual issues with patients and their families.	2.18	1.33
17. I am comfortable dealing with patients' and families' religious and cultural perspectives.	3.00	.89
18. I am comfortable providing grief counseling for families.	2.18	1.17
19. I am comfortable providing grief counseling for staff.	2.09	1.22
20. I am knowledgeable about cultural factors influencing end-of-life care.	2.09	1.14
Effective Care Delivery		
21. I can recognize when patients are appropriate for referral to hospice.	1.45	1.21
22. I am familiar with palliative care principles and national guidelines.	1.55	1.21
23. I am effective at helping patients and families navigate the health care system.	1.82	.87

Items	Mean	Std Deviation
24. I am familiar with the services hospice provides.	2.09	1.04
25. I am effective at helping to maintain continuity across care settings.	2.18	1.54
26. I feel comfortable addressing requests for ~~assisted~~ ~~suicide~~ medical assistance in dying (MAID).	1.91	1.51
27. I have personal resources to help meet my needs when working with dying patients and families.	2.09	1.45
28. I feel that my workplace provides resources to support staff who care for dying patients.	1.91	1.14

Note. N = 11.

The reliability statistics analysis using Cronbach's alpha score for the second survey used in the study was .954, indicating strong evidence of the degree of internal consistency of the instrument (Singh & Thirsk, 2022).

33-Item Emotional Intelligence Scale

The third and final instrument used in the study was the 33-Item Emotional Intelligence Scale (Schutte et al., 1998), with the results indicating a mean score of 131.56. The minimum range was 112 and the maximum range was 151, with a standard deviation of 15.72 (Table 6).

Table 6

Emotional Intelligence Scale Descriptive Statistics

	N	Minimum	Maximum	Mean	Std Deviation
Emotional Intel	9	112.00	151.00	131.56	15.72
Valid N	9				

The item questions with the highest emotional intelligence mean scores were: ‘I compliment others when they have done something well’; ‘Other people find it easy to confide in me’; and then followed by, ‘When I am faced with obstacles, I remember times I faced similar obstacles and overcame them’; ‘I seek out activities that make me happy’; ‘I help other people feel better when they are down’ (Table 7). In contrast, the three item questions with the lowest emotional intelligence mean scores were: ‘When I feel a change in emotions, I tend to come up with new ideas’; ‘I know what other people are feeling just by looking at them’; and ‘When I am in a positive mood, I am able to come up with new ideas.’

Table 7

Mean Item Scores of Emotional Intelligence Scale

Items	Mean	Std Deviation
1. I know when to speak about my personal problems to others.	4.22	.83
2. When I am faced with obstacles, I remember times I faced similar obstacles and overcame them.	4.44	.53
3. I expect that I will do well on most things I try.	3.89	.78
4. Other people find it easy to confide in me.	4.56	.73
5. I find it hard to understand the non-verbal messages of other people*	4.11	.60
6. Some of the major events of my life have led me to re-evaluate what is important and not important.	4.33	.71
7. When my mood changes, I see new possibilities.	3.89	.93
8. Emotions are one of the things that make life worth living.	4.22	.83
9. I am aware of my emotions as I experience them.	4.11	.60

Items	Mean	Std Deviation
10. I expect good things to happen.	3.78	.67
11. I like to share my emotions with others.	3.67	1.22
12. When I experience a positive emotion, I know how to make it last.	3.67	1.00
13. I arrange events others enjoy.	4.11	.60
14. I seek out activities that make me happy.	4.44	.73
15. I am aware of the non-verbal messages I send to others.	3.89	.78
16. I present myself in a way that makes a good impression on others.	4.11	.78
17. When I am in a positive mood, solving problems is easy for me.	4.11	.78
18. By looking at their facial expressions, I recognize the emotions people are experiencing.	4.00	1.00
19. I know why my emotions change.	3.67	1.12
20. When I am in a positive mood, I am able to come up with new ideas.	3.56	.88
21. I have control over my emotions.	3.67	1.00
22. I easily recognize my emotions as I experience them.	4.11	.60
23. I motivate myself by imagining a good outcome to tasks I take on.	4.0	.50
24. I compliment others when they have done something well.	4.78	.44
25. I am aware of the non-verbal messages other people send.	4.00	.71

Items	Mean	Std Deviation
26. When another person tells me about an important event in his or her life, I almost feel as though I have experienced this event myself.	3.78	.83
27. When I feel a change in emotions, I tend to come up with new ideas.	2.89	.60
28. When I am faced with a challenge, I give up because I believe I will fail*	4.33	.87
29. I know what other people are feeling just by looking at them.	3.33	1.22
30. I help other people feel better when they are down.	4.44	.53
31. I use good moods to help myself keep trying in the face of obstacles.	4.11	.78
32. I can tell how people are feeling by listening to the tone of their voice.	3.67	1.00
33. It is difficult for me to understand why people feel the way they do*	3.67	.71

Note. N = 9.

* These items are reverse scored.

The reliability statistics analysis using Cronbach's alpha score for the third survey used in the study was .941, indicating strong evidence of the degree of internal consistency of the instrument (Singh & Thirsk, 2022).

Results Related to the Research Question

This study focused on the following research question: What is the relationship between self-efficacy and emotional intelligence and fourth-year nursing students' comfort in providing

palliative and end-of-life care (PEOLC) for persons and families? This researcher hypothesized that higher levels of self-efficacy and emotional intelligence will relate to greater comfort by fourth-year baccalaureate nursing students' in providing PEOLC. Analysis of the findings exploring the relationship between the two variables, self-efficacy and comfort indicate the Pearson correlation, r = .778, p = .005 (Table 8). Next, analysis of the findings exploring the relationship between the two variables, emotional intelligence and comfort (Table 8) indicate the Pearson correlation, r = .791, p = .011. Bluman (2014) reported a correlation value of .6 to .8 is strong, as cited in Singh and Thirsk (2022). Also, it is important to consider the "minimum level of significance acceptable for nursing research is .05" (Singh & Thirsk, 2022, p. 384). This data indicates evidence to suggest there is a positive correlation between self-efficacy and comfort, as well as emotional intelligence and comfort of fourth-year nursing students in providing palliative and end-of-life care (PEOLC) for persons and families.

A post hoc power analysis was done to calculate the sample size with the correlation between comfort and self-efficacy at .778, with the following assumptions, desired level of alpha =.05, desired power =.80, and a 10% dropout rate. Using the sample size calculator at https://wnarifin.github.io/ssc/sscorr.html, the sample size needed was estimated to be 12. The correlation between comfort and emotional intelligence was found to be .791, using the above sample size parameters, the estimated sample size needed was 12. Seeing that this was a post hoc power analysis, the estimated sample size without the 10% drop-out rate needed was 10.

Table 8

Correlation Matrix of Self-Efficacy, Emotional Intelligence, and Comfort

		Self-Efficacy	Comfort	Emotional Intelligence
Self-Efficacy	Pearson Correlation	1	.778**	.668*
	Sig. (2-tailed)		.005	.049
	N	12	11	9
Comfort	Pearson Correlation	.778**	1	.791*
	Sig. (2-tailed)	.005		.011
	N	11	11	9
Emotional Intelligence	Pearson Correlation	.668*	.791*	1
	Sig. (2-tailed)	.049	.011	
	N	9	9	9

** Correlation is significant at the 0.01 level (2-tailed).

* Correlation is significant at the 0.05 level (2-tailed).

The following scatterplots demonstrate the comparison of the two scores and how the scores differ from the mean (Creswell, 2008) in relation to self-efficacy and comfort (Figure 2) and emotional intelligence and comfort (Figure 3). The information provided is "useful for identifying outliers and upper or lower ceiling effects of scores" (Creswell, 2008, p. 205).

Figure 2

Self-Efficacy and Comfort Scatter Plot

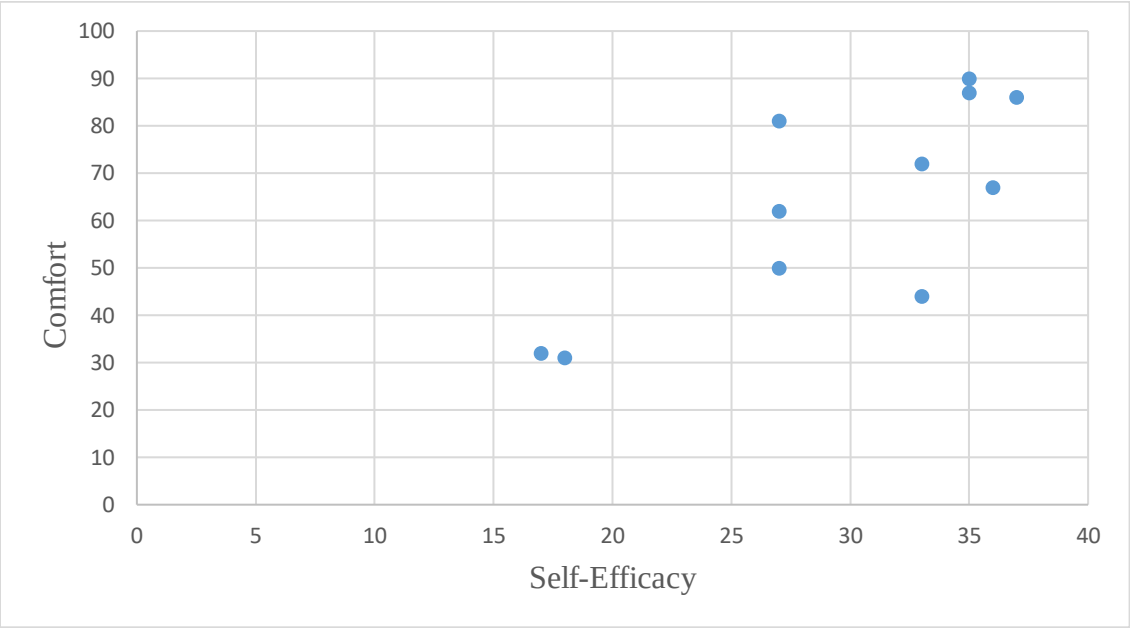
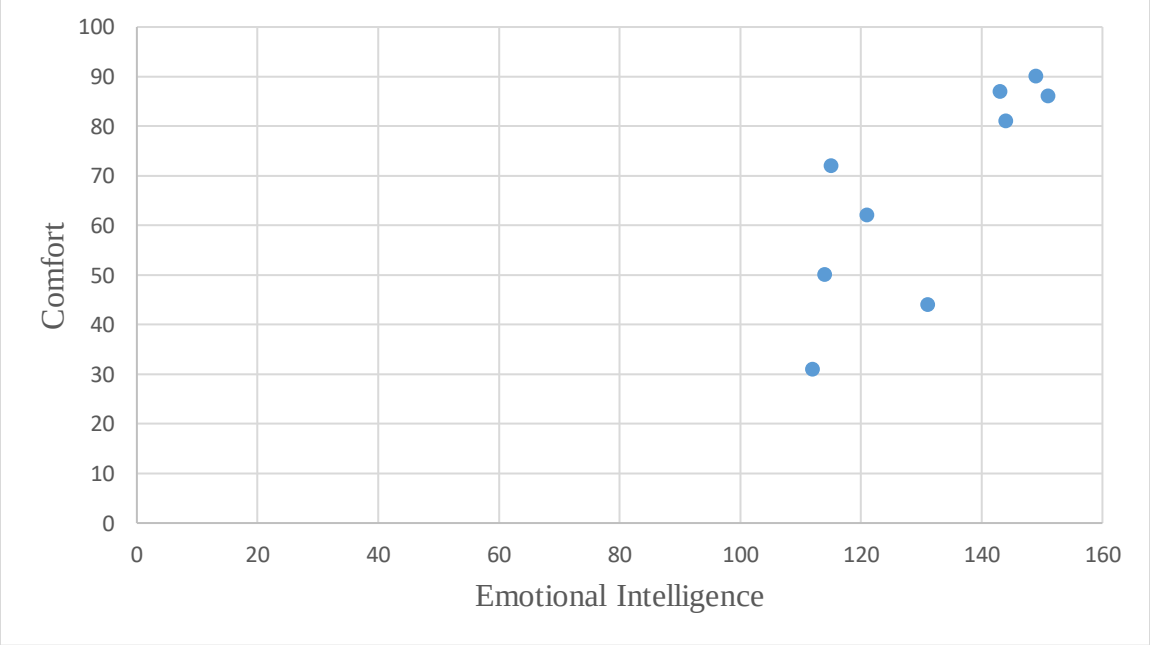


Figure 3

Emotional Intelligence and Comfort Scatter Plot



Results of the Study- Qualitative

Following the quantitative phase, two focus group meetings with five participants in each were planned based on interest expressed by 10 fourth-year baccalaureate nursing students during the first phase of the study. However, only one nursing student participated and attended the scheduled Zoom meeting for each of the two days scheduled for the meetings, and there were no emails received from the remaining eight nursing students communicating their absences. As mentioned, the timing of the qualitative data collection coincided with the sudden onset of the political and social unrest related to the Covid-19 restrictions involving trucker convoys and Canada/ United States border crossing blockades. In addition, nursing students were experiencing increased stress and anxiety related to curricular and clinical placement changes due to the pandemic (College of Nurses of Ontario, 2020; Joseph et al., 2022; Lee, 2022a). Nevertheless, two separate in-depth dialogues of the phenomenon and lived experiences (Parse, 1990) of two fourth-year nursing students were conducted using the ethics approved questions.

Guest et al. (2017) suggested that qualitative researchers need to consider the impact of certain factors, some of which include the degree of rapport and setting comfort. Effort was initiated by this researcher concerning these two factors, with the participants providing extensive information during the one-on-one dialogue. Guest et al. (2017) has also recommended that qualitative researchers consider the past experiences of participants. Both participants were female fourth-year baccalaureate nursing students who reported previous PEOLC experiences. The individual interviews allowed for detailed and complex data to be collected (Singh & Thirsk, 2022). Upon reflection on the data contained within the comprehensive transcriptions, this researcher asserts that the richness and depth of the data collected concerning the participant's lived experiences may not have been achieved within a focus group setting. Also, upon re-reviewing the post-dialogue field notes, it was documented "both (nursing student) participants

were very comfortable" discussing their PEOLC experiences, and their "openness and honesty" provided a greater understanding of the phenomenon being studied. This coincides with the use of information power (Malterud et al., 2016; Vasileiou et al., 2018) and the truth about the phenomenon being studied based on the description and testimony of the participant's personal circumstances (Parse, 2008).

The thematic data analysis occurred as follows: the first stage of the vertical analysis involved reading the interview questions and two transcripts multiple times in order to condense and summarize the material (Gaudet & Robert, 2018). During semantic condensation, the material was reduced based on the meanings related to the research question and clear definitions of terms (Appendix K) to support the rigour of condensation and validity of the research results, as stated by Gaudet and Robert. The horizontal analysis involved linking the analytical threads and connecting the categories to the research question (Gaudet & Robert, 2018). A concept map diagram was generated to assist with interpreting and reporting the themes and sub-themes (Vaismoradi et al., 2013).

Through thematic data analysis four themes were identified: Previous experiences with PEOLC enhances comfort; Need for PEOLC nursing education and teaching-learning strategies; Emotional impact of providing PEOLC; and Comfort level decreases with difficult PEOLC conversations and situations. All themes are described in more depth, with supporting quotes from the participants.

Previous Experiences with PEOLC Enhances Comfort

The two participants expressed how their previous experiences with PEOLC enhanced their comfort level in this area of nursing practice. Prior life experiences, nursing education, and work experiences were reported to have played a significant role and have influenced how they view their comfort level. The first participant stated:

> I'd say I have had experiences in all three categories (*life, education, work*).

She went on to further explain the impact of her life-experience when her grandmother was palliative and during the end-of-life stage. During this life-experience the participant was a nursing student in the nursing program, which seemed to have an effect on her familial role:

> I kind of had to explain to my family what was going on and that this is what they are going to do to keep her comfortable and all of these things, so, I think that brought me closer too.

Similarly, the second participant also stated how a previous experience strengthened her and enabled her to learn to deal with death and loss:

> I have had a close friend pass away, umm and I think that shaped a lot of my mind set, because that was the summer before I started nursing school. Umm and to go through that. I think… Not that it was a good thing but it definitely you know strengthened me and allowed me to, I guess, understand what it's like to deal with that loss, especially a tragic one.

The participants also shared how previous life experiences served as a catalyst for them to pursue a career interest in this specific area of nursing practice. The first participant highlighted this point:

> … like I love palliative care and end-of-life care so much so, I think that is the bond that I have with it, relating it to my life.

Both participants said they have a certain level of comfort with PEOLC in relation to their current clinical placements and work terms. The first participant said:

> My placement right now is actually on cancer palliative care, so it is like half cancer and half palliative care and that's where I want to work. Umm and I have been working there

> throughout the summer as an extern, so I have become, I never want to say used to it, but I guess Ok with it.

Likewise, the second participant described her clinical placement and work term as follows:

> I'm in emergency… I wouldn't choose such a high acuity, you know, and I'm sure I will see death. I wouldn't choose something like this if I wasn't comfortable, right, to a certain extent… Just recently you know in Covid I worked in the ICU as an extern…so I saw a lot of death, a lot of intubations and ventilations. I saw a lot of people you know dying.

The participants described the importance of exposure to PEOLC in baccalaureate nursing education and the need for increased discussions to enhance comfort and to enable students to consider this area for future nursing practice. The first participant expanded on the importance of this point:

> I think that if it is talked about more, people will think to themselves oh maybe this is something that I am interested in. Maybe this is a field I want to work in. Because I have heard a lot of stories about people who they don't want to do palliative care and they are like oh I could never see myself working in an environment like that. It is so sad. I couldn't do it. And they end up working and they fall in love with it. So, I think more exposure would help.

The second participant also emphasized the importance of exposure to experiences to enhance comfort in providing PEOLC:

> I feel like somebody has to experience that actual palliative and end-of-life care, umm, before you can actually feel how prepared you are, or could you provide it at all.

The first theme highlights the influence of previous experiences and the importance of educational experiences of baccalaureate nursing students and how they impact comfort level in

the provision of PEOLC for patients and their families. Previous life experience with PEOLC is a deeply personal experience and can have a significant effect on a baccalaureate nursing student. Emerging from this theme is the need for palliative and end-of-life care nursing education and the inclusion of teaching- learning strategies within the curriculum that will assist in achieving these competencies.

Need for PEOLC Nursing Education and Teaching-Learning Strategies

Baccalaureate nursing programs can ensure that the baccalaureate nursing student has an opportunity to develop the PEOLC competencies required for a registered nurse graduate. In this research study, the students expressed a need for further focus and depth on PEOLC to be incorporated across the baccalaureate nursing degree curriculum. The first participant said the following:

> I'd say there is definitely not enough education on palliative care … I think we only spent like maybe a day or two talking about it in my med-surg unit, so, definitely there should be more… I mean I don't know if anything can fully prepare you for palliative care and the things that come along with it. But it definitely should be talked about more.

The nursing student expanded on the need for PEOLC nursing education:

> If I remember correctly, [we] talked about the physical, what the palliative patient looks like, what meds you are giving them… that's about it… I do think that it is important and to carry it on throughout the years… People forget about it.

Similarly, the second participant highlighted the need for further focus on PEOLC:

> …there have been many conversations…especially in first and second year. Many lectures were based on palliative and advanced age, and dementia… but there was never a clear focus on it.

The student participants expressed how they thought that their nursing education had benefited them in relation to providing specific aspects to physical care such as medication administration, pain management, promoting client-centred care, and advocating for their patients. By contrast, they recommended that nursing education should focus more on communication, and as well the emotional and psychological aspects of providing palliative and end-of-life care.

Both participants suggested integrating active and diverse teaching-learning strategies, such as case study scenarios, videos, virtual reality, and simulation opportunities that focused specifically on PEOLC within the curriculum. The second participant shared the positive and beneficial learning experiences in a community health nursing course "during Covid" with a virtual experience titled "Journey north: A virtual nursing experience" (Red River College Polytech, 2014) and a documentary called "Bevel up" (National Film Board, 2007). The participant suggested how important it was to have similar learning experiences to aid in increasing one's understanding of PEOLC situations. The first participant commented on this idea:

> Maybe it would help if they did scenarios, things like that, or even like watching videos. I'm not sure if there are videos about how to approach (patients and families). Because I know when I learned about palliative care it was just like slides, slide shows, talking about the physical aspect. No one really talked about the emotional aspect, or the psychological aspects of it.

There were repeated patterns of engagement when the second participant said:

> Nursing schools can implement more simulations because personally I have never had one dealing with end-of-life care or managing a palliative client … to actually immerse us and to make us think about it, experience it. I think that would be beneficial.

Baccalaureate clinical experiences may not always provide opportunities for nursing students to care for patients and their families during end-of-life. Simulation learning experiences, immersive virtual reality (VR) and documentaries may provide supportive PEOLC learning opportunities. The participants also recognized that nurses will be required to provide end-of-life care during their careers, regardless of the area of nursing practice they work in. The first participant remarked:

> For the four-year program I don't think we are placed in long-term care unless there is no other spot, so not everyone is getting exposed to that (PEOLC), or if you are not on a transitional unit then you might not be getting exposed to that, or if you are not on a cancer or palliative care unit your probably not getting exposed to that… but I definitely think it is beneficial … it is something that you are going to come across for sure in your nursing career.

The second participant supported this view:

> I think almost every nurse, no matter where he or she works, or what they do, you will see it (PEOLC). And that's why I don't think it is talked about enough.

The importance of PEOLC nursing education and the need for integration of diverse and interactive teaching-learning strategies throughout the four-year undergraduate nursing curriculum promotes safe and quality care for patients and families, in addition to ensuring nurse graduates are able to manage the emotional impact of providing PEOLC.

Emotional Impact of Providing PEOLC

Caring for patients and their families during end-of-life can be emotionally difficult for baccalaureate nursing students. The first participant said:

> … in palliative care situations I find it, it's not ever easy, but I know how to I guess compose myself…it is a lot of emotional stress, especially if you are not comfortable with it… they are hard conversations to have.

Demonstrating empathy is a significant element of nursing practice. It is the ability to imagine or understand what a person is experiencing and to sense his/ her emotions. The second participant expressed her thoughts about the emotional impact of providing PEOLC in relation to empathy in the following way:

> …because of those feelings … I empathize with people and it does have an impact on me sometimes.

The participants shared the degree of emotional impact when caring for PEOLC patients and their families may not have been fully understood as young adults when entering the baccalaureate nursing degree program and nursing profession. The second participant elaborated on this fact and stated:

> I guess me and I'm sure a lot of nursing students and even novice nurses; I don't think we realized that when we choose this profession, how much of this we will see and how much of this we will encounter. I know that they say "you will see death" but until you really see the suffering and see how that impacts a client and their family and everybody around them, you really don't get it. It's not talked about enough... And it impacts you. I'm not even a nurse yet and it has impacted me.

The participants suggested that continued learning and experiences are essential to be able to manage emotions and to deal with the emotional impact of end-of-life experiences. The first participant elaborated on this idea:

> Being there for someone is what it is about for me. I'm learning more and more every day about how to talk to families during hard times like that.

The second participant expanded further on learning how to manage the emotional impact:

> It is difficult to separate and try not to take home with you… It is almost something you have to tell yourself. I can't let this affect me when I come home to my family, but at the same time we need to have the time to process it… we can't completely detach from it because it makes us us; it makes us who we are. It is a difficult thing. It's hard, it's something that you can't quite let get to you, but it's something you do need to deal with- I can see that it is something I'm going to have to learn.

Emotional impact is linked to theme four which focuses on the nursing student's comfort level in providing PEOLC for patients and their families.

Comfort Level Decreases with Difficult PEOLC Conversations and Situations

The participants expressed a level of comfort related to various aspects of providing care for patients during the palliative and end-of-life period. Factors which seemed to influence this comfort level related to their previous personal, work, and nursing educational PEOLC experiences, identified as the first theme in this study. Participants said specific areas of comfort were related to the provision of physical care such as keeping the patient comfortable via non-pharmacological interventions, pain management, medication administration, and advocating for the patient.

In contrast, comfort level was reported to decrease when communicating and answering more difficult questions from patients and family members. At the same time, the participants stated that, as senior baccalaureate nursing students, they had access to the support of preceptors and staff on the unit to assist them with more difficult conversations and situations. The first participant said:

> In answering questions I never want to say, you know, the wrong thing… so always under supervision now with my preceptor, I'll always shadow her when she is answering

> questions… the conversations can be really hard to have and as a student it is interesting for me because in my head I'm thinking oh is this crossing a boundary asking these questions or is it making the family feel uncomfortable… getting to that stage … transitioning to end of life you have to ask these questions to keep the patient comfortable and find out what they really want… usually I would probably defer to my preceptor.

In an effort to prepare senior nursing students to be able to manage difficult PEOLC conversations and situations, developing the necessary communication and judgment skills was an area of discussion. The first participant said:

> I mean I don't know if anything can fully prepare you for palliative care and the things that come along with it… should be talked about more, like I said the communication aspect of it… it's a lot of conversations you are having, they are uncomfortable conversations because you don't want to say the wrong thing… So, I think teaching communication skills… it also comes with your judgement as well, your nursing judgement on how to approach situations and what not to ask and what to ask.

The second participant also stated:

> There are some questions that I probably would not be able to answer, just because I don't have that experience yet. I don't have that judgement yet.

In addition, responding to difficult questions with regards to legal and legislative issues on PEOLC was also a topic of dialogue. The second participant said, "there are certain questions I'm sure I wouldn't be able to answer", "like legal matters" related to PEOLC. Both participants commented on the fact that they had educational opportunities to write scholarly papers on the topic of medical assistance in dying (MAID) within the nursing curriculum. However, the participants stated they have not been a witness to a patient receiving MAID, nor have they been

present to provide support for loved ones following this procedure. The first participant expanded on this idea:

> I've met patients who have wanted to have MAID done. I've never been there, I've never seen it being done, but it definitely happens on my unit.

The second participant also commented on the idea of direct experience with MAID:

> I have never had a client that has requested MAID or has had that procedure while I was a student. I've never seen it. However, I have thought about it many times.

Both participants shared their personal viewpoints concerning the current legislation involving MAID. The first participant said:

> …my view on MAID now is if someone has a terminal illness and this is the way that they want to pass and pass with dignity then I agree.

The second participant also remarked:

> I have always been on the side for it.... As nurses we are supposed to respect that autonomy. We are supposed to advocate for them. All about client centered care.

Without prompting, additional dialogue occurred regarding the proposed changes in the future to the MAID legislation and the potential impact of nurse comfort in the provision of care with patients and their families. The first participant said:

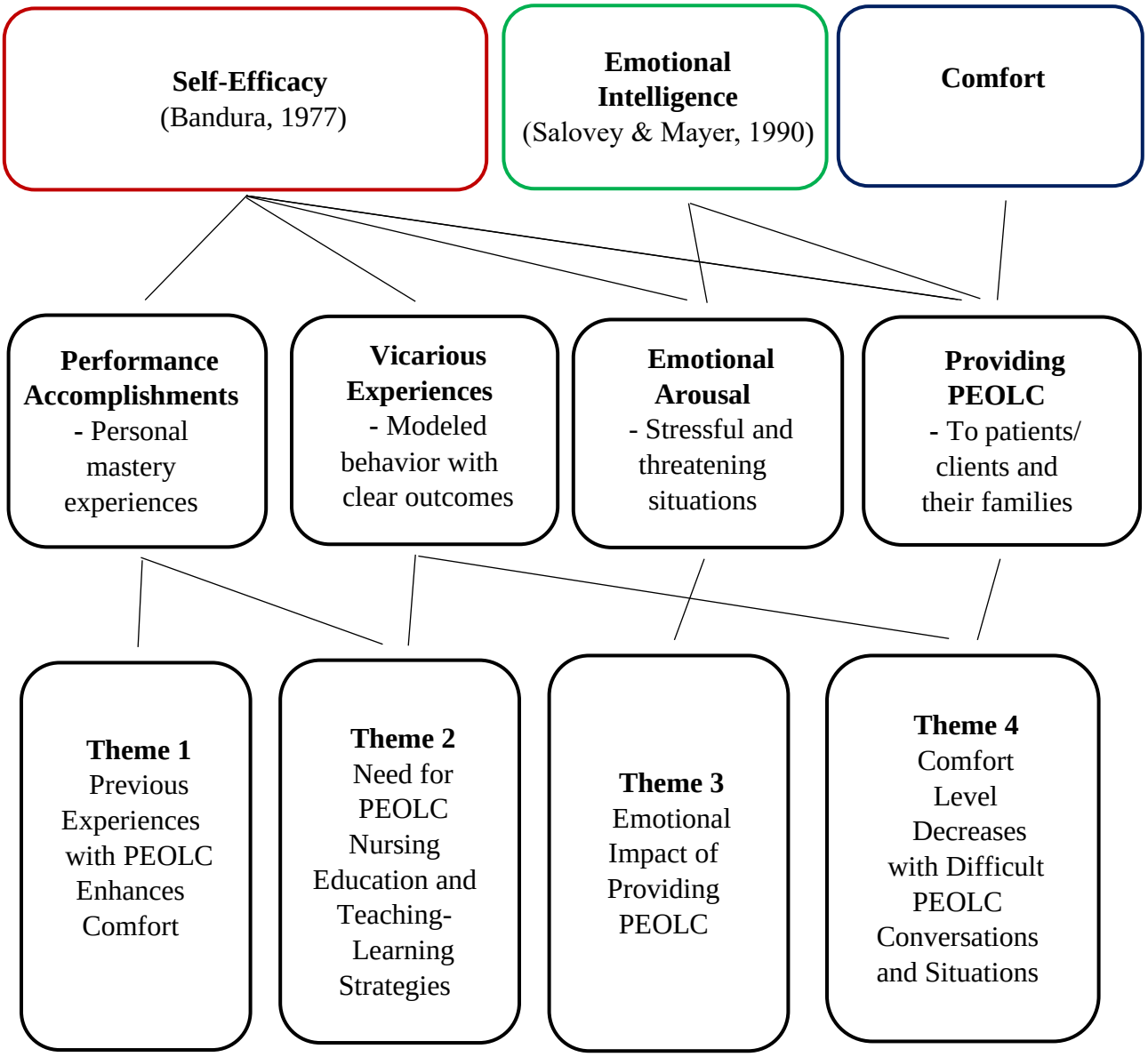
> … It will definitely impact my comfort because I was on the stance where I don't know if I agree or not with the mental health and I find it kind of vague. It might be different than what I think in my head. The rules might be different.

By comparison, the second participant said:

> I've heard that there is a change planned, pardon if I am wrong about the year, I want to say next year that they are planning on and hoping to allow patients with strictly mental health issues to request this procedure and even then, I would still be for it.

In summary, figure 4 provides a visual concept map of the relationships between Bandura's (1977) self-efficacy framework and sources of information, Salovey and Mayer's (1990) definition of emotional intelligence, and comfort of fourth-year nursing students in providing PEOLC. The four themes identified in this study are demonstrated visually as they relate to the theoretical framework, definitions, and research question variables.

Figure 4- Concept Map: Relationships and Themes



Data Integration and Summary of Findings

Findings from the two separate quantitative and qualitative data analyses were compared and integrated in an effort to "develop an overall interpretation" (Polit & Beck, 2017, p. 591). The integration of these findings is summarized using a narrative approach in the following paragraphs (Polit & Beck, 2017).

The findings of this study indicate a positive correlation between self-efficacy and comfort, as well as emotional intelligence and comfort of fourth-year nursing students in providing palliative and end-of-life care (PEOLC) for persons and families. Additionally, consideration of the findings from the quantitative and qualitative data analyses offers further details on PEOLC experiences of baccalaureate nursing students and an increased understanding of the research variables and their connection to undergraduate nursing education.

Through their responses to the Palliative Care Self-Efficacy Scale (Phillips et al., 2011) instrument, participants identified their highest self-efficacy mean scores when reacting to patient reports of pain, constipation, and nausea/ vomiting, all of which are common nursing practices with diverse patients in various clinical areas. In contrast, lower self-efficacy mean scores were associated with reacting to and coping with terminal dyspnea and terminal delirium, in addition to answering patient questions about the dying process and discussing patient wishes after their death. The identified lower self-efficacy items are specific to communicating with patients about death and dying and providing effective care during advance care planning and the end-of-life stage.

Similarly, the results of the End-of-Life Professional Caregiver Survey (Lazenby et al., 2012) identified that participants were comfortable documenting patient needs and interventions, being present with the dying patient, and collaborating with other health care professionals about the care of dying patients. By contrast, lower confident mean scores were related to

communication and effective care delivery subscales (Lazenby et al., 2012), specifically helping patients/ families accept a poor prognosis, helping patients/ families resolve difficult conflicts about end-of-life care, recognizing appropriateness of referral to hospice, and being familiar with palliative care principles and national guidelines.

From the qualitative data results, the nursing student participants described the provision of physical care such as keeping the patient comfortable via non-pharmacological interventions, pain management, medication administration, and advocating for the patient as areas in which there was a level of comfort and self-efficacy. Similar to what emerged in the quantitative results, this level of comfort decreased when communicating and answering more difficult questions concerning end-of-life from patients and especially with family members.

The qualitative findings highlighted how nursing education benefited the student nurses in relation to providing physical care, client-centered care, and advocating for their patients. However, increasing the time, focus and depth of nursing education on communication and judgment skills, exploring the emotional and psychological aspects related to providing PEOLC care, as well as examining the relevant legal and legislative issues were recommended. Suggestions were provided about integrating within the curriculum diverse teaching-learning strategies, such as case study scenarios, videos, documentaries, virtual reality, and simulation opportunities to aid in achieving the above recommendations.

In addition to nursing education, participants indicated how it is helpful for educators to consider nursing students' previous life and work experiences can have a potential impact on their level of comfort with providing palliative and end-of-life care. The research findings also revealed how previous experiences with end-of-life care can be influential and increase nursing students' interest in pursuing careers in this area of practice.

Based on the 33-Item Emotional Intelligence Scale (Schutte et al., 1998), participants identified higher mean scores in their ability to compliment others when they have done something well, felt people are able to confide in them, and have the ability to help people when they are feeling down, all emotional intelligence attributes important as a practicing registered nurse. In contrast, lower mean scores were identified when feeling a change in emotions and coming up with new ideas, as well as appraising other people's feelings by way of visual assessment. Based on Salovey and Mayer's (1990) definition of emotional intelligence, these lower scored items can be associated with one's self-reported ability to appraise the emotions of others and utilize emotions to guide one's thinking and actions. The ability to solve problems, use judgement skills, and think critically during situations in which the graduate nurse may experience emotional responses are essential competencies in the provision of effective and safe care for patients and their families. It is also essential for self-care of the nurse.

The qualitative findings also supported the quantitative findings with regards to emotional intelligence. Through dialogue the participants described that caring for patients and families during PEOLC can have an emotional impact on the student nurse. Participants shared how providing care for and empathizing with patients and their families during end-of-life can be difficult, emotional, and have a resulting personal impact. It was suggested that this potential impact should be discussed more within baccalaureate programs in order to prepare nursing students for the emotional responses they may experience and to learn strategies to process and deal with the feelings associated with difficult PEOLC conversations and situations. Further explanation was provided by the study participants in that, when choosing the nursing profession, often one does not realize the frequency in which death and dying will be seen by the student and new graduate nurse in various clinical settings, and as well the level of impact on the patient and their family in these types of situations. These findings emphasized how nursing

students can experience emotional responses such as loss and grief as a result of the care they provide during their nursing education and within their chosen profession.

The ongoing changes to legislation involving medical assistance in dying (MAID) can also produce an emotional response or ethical dilemma for the nursing student. The importance of dying with dignity and advocating for the patient's wishes in relation to MAID was discussed during the qualitative phase. Incorporating written assignments to explore the topic of MAID within the baccalaureate nursing program was reported and supported by the study participants. All participants in this research study (Table 1) reported having had no previous experience with persons requesting MAID, which is an important finding for nursing programs to consider with regards to entry-to-practice competencies for registered nurses (College of Nurses of Ontario, 2019) and ongoing legislative changes involving MAID.

Chapter 5- Discussion, Limitations, Recommendations and Conclusions

In chapter 5, the discussion, limitations, recommendations, and conclusions are described. The discussion highlights the purpose of this study, the research findings as they compare to previous research, and the literature concerning the theoretical framework and definitions used in this study. Identified limitations, future recommendations for practice, suggestions for further research, and final conclusions are also described in this chapter.

Discussion

The purpose of this mixed-methods study intended to explore the relationship between self-efficacy and emotional intelligence and fourth-year nursing students' comfort in providing palliative and end-of-life care for persons and families. Bandura's (1977) self-efficacy theory and Salovey and Mayer's (1990) definition of emotional intelligence were used as the theoretical framework for this research. The study findings support the importance of nursing students' perceived capability to effectively perform, as well as manage emotions, in relation to being comfortable in providing palliative and end-of-life care (Bandura, 1994; Salovey & Mayer, 1990).

Previous studies have found there is inadequate prelicensure education on end-of-life, resulting in nursing students feeling ill prepared and uncomfortable to properly care for patients and their families (Carvalho et al., 2020; Dame & Hoebeke, 2016; Lippe et al., 2017; Strang et al., 2014; White & Coyne, 2011). The quantitative results of this research study identified there were specific areas of PEOLC nursing practice in which fourth-year nursing students reported reduced self-efficacy, emotional intelligence, and comfort in the provision of care. Reduced self-efficacy were related to areas when caring for a person with terminal dyspnea, terminal delirium, answering questions about death and dying, and discussing patient wishes after their death were identified. Based on Salovey and Mayer's (1990) definition of emotional intelligence, one's self-

reported ability to appraise the emotions of others and utilize emotions to guide one's thinking and actions were recognized as challenges by nursing student participants in this study. Also, reduced confident scores were associated with difficult PEOLC conversations, providing aspects of effective care delivery during end-of-life, and being familiar with palliative care principles and national guidelines.

Students' beliefs about their self-efficacy can be developed through performance accomplishments, vicarious experiences, and interpreting their emotional states to assess their capabilities (Bandura, 1994). Bandura (1977) proposed performance accomplishments and mastery experiences can have an influence on personal efficacy. In this study, nursing student participants reported their previous experiences with PEOLC had an impact on their self-efficacy and enhanced their comfort levels. Research by Oluwatomilayo et al. (2014) involving third-year Australian nursing students also supported that having a history of previous personal and professional experiences had a positive influence on end-of-life care nursing practice.

Educators have an important role to play in creating conducive learning environments that can have an impact on students' perceptions of their capabilities, academic accomplishments, and future aspirations (Bandura, 1994). Sook and Kyung (2019) suggested that nurse educators consider the self-efficacy theory when planning and designing clinical experiences for nursing students. Mayer and Salovey (1993) stated that self-efficacy is linked to emotional intelligence in which competencies encompass a student's ability to appraise, regulate, respond and utilize emotional content to effectively solve problems and guide actions. A strategy recommended to strengthen nursing students' problem-solving skills and clinical performance is for educators to "systematically analyze the subcategories of emotional intelligence and apply them to the curriculum" (Sook & Kyung, 2019, p. 386). There is agreement of the importance of

integrating emotional intelligence within the nursing curricula (Aradilla-Herrero et al., 2012; Rice, 2015).

Vicarious experience refers to viewing others perform or model activities without negative consequences, which then generates feelings of persistence and improved personal self-efficacy (Bandura, 1977). The findings from this study identified the need for diverse and interactive teaching-learning strategies and additional PEOLC nursing education within the baccalaureate program to have these experiences. The traditional teaching method of didactic lectures may not provide necessary opportunities for nursing students to develop their communication skills, nor the time needed to reflect on personal beliefs and emotional reactions when caring for dying patients and their families (Gillian et al., 2014). Lippe et al. (2017) supported the need for curriculum reform and alternative teaching-learning strategies, placing an emphasis on curriculum mapping and shifting from teacher-centered activities to learner-centered activities in which students are actively participating and engaged in critical inquiry. Gillian et al. (2014) also recommended incorporating diverse teaching strategies to provide opportunities for critical reflection and appropriate depth of theoretical content related to PEOLC within the nursing curricula. Integrating significant and meaningful learning experiences within the curriculum has an impact on students' educational success (Fink, 2013).

The participants in this study suggested integrating within the nursing curriculum diverse teaching-learning strategies on PEOLC, such as case study scenarios, videos, documentaries, virtual reality, and simulation opportunities. These findings are supported in the literature. Colley (2016) recommended the use of case studies and high-fidelity simulations to enhance nursing students' comfort and confidence in providing end-of-life care. Exposure by way of realistic end-of-life scenarios was recommended by Cheon and You (2022) as a method to provide nursing students with "opportunities to learn how to accept death, how to provide end-of-life

information, and how to communicate with patients and families" (p. 5). Research by Strang et al. (2014) highlighted the value of nurse educators in integrating learning opportunities for simulated scenarios, supervised reflection, and drama to assist students with overcoming their fear of caring for dying patients. The authors proposed that students' confidence to "fulfil their expectations concerning their future proficiency" may be enhanced (Strang et al., 2014, p. 199).

The use of high-fidelity end-of-life simulation in nursing education is recommended in the literature as providing a safe, interactive, and effective learning environment for baccalaureate nursing students in which they can gain comfort and confidence in communication skills, knowledge, and ability to provide palliative and end-of-life care (Colley, 2016; Dame & Hoebeke, 2016; Dunn et al., 2014; Fabro et al., 2014; Kunkel et al., 2016). There has also been recent attention in the literature on integrating and evaluating virtual reality (VR) and virtual patient (VP) simulations in nursing education, as a supportive teaching-learning strategy particularly in response to the Covid-19 pandemic (Chang & Chin, 2021; Hwang et al., 2022; Lee, 2022b; Liu & Butzlaff, 2021; Silva et al., 2022). This teaching-learning strategy provides nursing students with an opportunity to use video technology within an environment similar to clinical contexts to make decisions, enhance confidence, self-efficacy, and to perform clinical practice competencies (Chang & Chin, 2021; Hwang et al., 2022; Lee, 2022b; Liu & Butzlaff, 2021; Silva et al., 2022).

Research conducted by Bobianski et al. (2016) involved the design and planning of a community simulation apartment which focused on learning competencies associated with cultural components, communication skills, and end-of-life care, as outlined by the American Association of Colleges of Nursing. During the post-simulation debriefing phase, strategies in which positive coping mechanisms for nursing students to use were discussed (Bobianski et al., 2016). Similarly, Carvalho et al. (2020) conducted a research study in a community course, in

which nursing students completed reflective questions after role playing in two end-of-life scenarios which took place in a simulated home environment on campus. The results supported integration of simulation through role play as an effective end-of-life teaching and learning strategy (Carvalho et al., 2020).

Incorporating other forms of reflective learning experiences, such as using videos for observation and feedback, providing supportive supervision, and role modelling, are additional teaching-learning strategies suggested to foster self-awareness, an aspect of emotional intelligence (Beauvais et al., 2011). Reflective journal writing and guided journal prompts were also supported as teaching-learning strategies to improve emotional intelligence and critical thinking (Carter et al., 2006; Harrison & Fopma-Loy, 2010; Rice, 2015). Gardner (2000) recommended that recognizing the engrained theories or ways of thinking a person develops can be challenged in order to produce enhanced or different ways of thinking, by incorporating role play, logical arguments, and storytelling in education.

Similar to storytelling, the use of arts-based expressions through music, drama, paintings, pictures, metaphors, poems, videos, and films were explored in an Advanced Nursing Praxis with Persons Experiencing Loss and Grieving course (Dr. Jonas-Simpson, personal communication, Summer, 2019), taken during this researcher's PhD education. Artistic expression or arts-based inquiry can provide learning opportunities for nursing students to understand their emotions and foster emotional reasoning (Mayer & Cobb, 2000), to express thoughts and feelings related to their educational experiences (Condon, 2009) and to enhance inquiry and critical thinking (Casey, 2009). As an example of a personal arts-based expression, a poem (Appendix L) was created connecting the lived experience of this researcher as a nurse educator and the challenges associated with teaching death, dying, loss, and grief.

In addition to the need for diverse teaching-learning strategies, nursing student participants in this study recommended further education on PEOLC theory be incorporated within the nursing baccalaureate curriculum. Oluwatomilayo et al. (2014) studied how nursing students perceived their level of education and knowledge, with many participants reporting that the end-of-life education in the nursing curriculum was not adequate. The authors identified the need for a greater focus of end-of-life care within the program and highlighted the importance of seeking ongoing feedback from nursing students regarding integration within the curriculum (Oluwatomilayo et al., 2014). Obtaining ongoing feedback from senior students and reviewing the literature are recommendations made by Colley (2016) as ways to assist nursing educators to discover the best strategies to educate nursing students on end-of-life care and to improve achievement of established learning outcomes and required professional competencies.

Using the backward design approach is suggested in the literature as a method for educators to strengthen and improve the curriculum in nursing education (Emory, 2014; Maldonado, 2022; White & Maguire, 2021). Wiggins and McTighe (2005) originally described the approach in which the desired results or learning outcomes are identified, followed by determining acceptable evidence, and then planning the learning experiences. The backward design process can be used to map an educational plan to achieve the desired outcomes of enhancing nursing students' self-efficacy, emotional intelligence and comfort in providing PEOLC to patients and their families (Maldonado, 2022; Wiggins & McTighe, 2005).

Students' beliefs about their self-efficacy can also be developed by interpreting their emotional states to assess their capabilities (Bandura, 1994). Mayer and Salovey (1993) stated that self-efficacy is linked to emotional intelligence. The findings in this study highlighted the emotional impact on nursing students when providing end-of-life care and decreased comfort levels when exposed to difficult PEOLC conversations and situations. Cheon and You's (2022)

research reinforced how nursing students feel emotions such as grief and ethical distress when experiencing a patient's death during clinical practice. This notion of emotional impact regarding loss and grief is exemplified in the documentary titled 'Nurses grieve too: Insights into experiences with perinatal loss' (Jonas-Simpson, 2010).

The nursing student participants in this study described personal insights on the emotional impact of providing PEOLC. Having insights into experiences or meta-awareness, a term used by Payne (1985), is a strategy in which nursing students can pay particular attention to the environment and their emotional state by intentionally tuning into the present moment. Meta-awareness (Payne, 1985) can be particularly relevant when examining emotions related to end-of-life care, death and dying, and the evolving legislation concerning MAID. If the baccalaureate nursing student has never cared for a client requesting MAID, personal and professional moral reflection (Pesut et al., 2019) is recommended as it relates to the legislation and increasing options for patients concerning end-of-life. Pesut et al. (2020) also emphasized the importance of reflection on the concept of conscientious objection to protect the rights of healthcare workers regarding any moral or ethical conflicts. Further explanation on the importance of reflection is provided in that nurses have "an ethical and a professional responsibility to reflect carefully and critically about their decisions to participate, or not, in MAID" (Pesut et al., 2020, p. 2).

Cheon and You (2022) reinforced that nursing students should receive education examining various scenarios on death and dying involving patients and their families. Corcoran's (2016) study supported the idea "that when professional caregivers are empowered with structured education, comfort in delivering EOL care improves" (p. 109). Providing education opportunities for baccalaureate nursing students to reflect on personal and professional meanings of ethical care and advocating for patients and families during end-of-life will empower future graduate nurses to respond to the ongoing changes of societal and legislative practices. In

addition to the legislation on MAID and the associated competencies outlined by the College of Nurses of Ontario (2019), it is important for new nursing graduates to have the required knowledge and comfort with the guiding principles and best practices outlined in the Framework on Palliative Care in Canada (Government of Canada, 2019), as well as the applicable and relevant professional practice standards, guidelines, and required competencies concerning end-of-life care and advance care planning (Advance Care Planning Canada, 2022; Canadian Association of Schools of Nursing, 2011; Canadian Nurses Association, 2022a, 2022b; College of Nurses of Ontario, 2019, 2023).

Limitations

This researcher recognized that a number of limitations had an impact on this research study. First, since 2020 the Covid-19 pandemic has had a significant and negative impact on graduate research. A study by Sutherland et al. (n.d.) highlighted the overall impact of Covid-19 on Massachusetts Institute of Technology (MIT) researchers with 88.7% of respondents stating that they had been negatively impacted by the pandemic. Diverse barriers and challenges were experienced by graduate researchers, such as lack of in-person research, having to pivot to remote research, and "fear of not collecting enough data" (Sutherland et al., n.d., p. 15). This researcher experienced having to shift to remote research, in addition to having a lower than anticipated participation rate. As previously described, every effort was initiated to mitigate this last challenge. When doing research, one has to be cognizant of the influence of local and national political, social, and environmental factors, and the potential impact these factors can have on research activities. For example, the fourth wave of the pandemic involving the Omicron variant occurred during the quantitative data collection phase in the fall of 2021, while nursing students had been under exceptional stress for at least 20 months by this time. In addition, the trucker convoy protests occurred during the qualitative data collection phase in winter of 2022.

As a result of the Covid-19 pandemic, fourth-year nursing students also experienced challenges related to in-class education, as well as access barriers to on-campus resources and clinical placements. Senior baccalaureate nursing students are extremely busy with their academics in the final year and are preparing to study for the national council licensure examination (NCLEX) to be a registered nurse (RN). With such disturbing and stressful times affecting fourth-year baccalaureate nursing students, it is this researcher's assumption that these events may have impacted nursing students' ability and willingness to participate in this research study. As such, a smaller sample size than anticipated was involved in this study.

In relation to this research study involving a correlational design, a limitation or internal validity factor is that preexisting groups were not formed at random, which is referred to as selection bias (Polit & Beck, 2017). Fourth year baccalaureate students were invited as participants for this study because this group is in their final year of the undergraduate nursing program and nearing graduation. Also, with lack of manipulation in a correlational study and randomization, there is an inability to draw causal statements (Lobiondo-Wood et al., 2018). Similarly, there is a potential challenge with external validity and interpreting correlational findings in the real world, specifically, involving palliative and end-of-life comfort levels of nursing students, as variables are inter-related in complex ways (Polit & Beck, 2017). The qualitative phase of this study enhanced and strengthened the quantitative findings and offset, to some extent, the discussed limitations of a correlational design.

Despite the identified limitations, the quantitative findings yielded 749 item-specific data results with evidence to suggest a statistically significant correlation between self-efficacy and comfort, as well as emotional intelligence and comfort of fourth-year nursing students in providing PEOLC for persons and families. Similarly, the qualitative findings yielded detailed rich data from two fourth-year nursing students on their lived experiences (Parse, 1990)

involving PEOLC. There were similarities in the PEOLC experiences described by the nursing student participants within the qualitative findings, resulting in four identified themes.

Recommendations

Baccalaureate nursing students require relevant and meaningful learning opportunities to enhance their self-efficacy regarding PEOLC knowledge and skills, in addition to developing strategies to manage and utilize their emotions to effectively problem solve and comfortably provide safe care for patients and their families. The following recommendations may assist with achieving this overall goal**.**

The first recommendation is to consider Bandura's (1977) self-efficacy theory and Salovey and Mayer's (1990) emotional intelligence definition within baccalaureate nursing programs when planning, integrating, and evaluating learning opportunities to enhance the comfort of nursing students in providing PEOLC to patients and their families. Identifying and integrating a programmatic agreed-upon working theoretical framework and definition of self-efficacy and emotional intelligence for curricular design and development decision-making and evaluative processes are helpful first steps.

The second recommendation is to consider the literature on PEOLC teaching-learning strategies and the process of backward design (Emory, 2014; Maldonado, 2022; White & Maguire, 2021) when planning, implementing and evaluating interactive, reflective, and experiential learning opportunities during curriculum development and course revisions. Based on this study, participants suggested the inclusion of diverse teaching-learning strategies such as case study scenarios, videos, virtual reality, and simulation opportunities that examine additional PEOLC theory, concepts, and applicable legislation.

Carmack and Kemery (2017) recommended ongoing evaluation of teaching-learning strategies in relation to achievement of the learning outcomes and the impact on student comfort

and the care provided to patients and the families during end-of-life. This supports the third recommendation for ongoing evaluation of achievement of the required professional competencies, program goals and course learning outcomes, as they relate to the specific theory, concepts, and legislation on PEOLC. The literature and results of this research study, although not generalizable, did highlight the need to increase time, focus, and depth of learning with regards to areas of nursing practice associated specifically with palliative and end-of-life care. Reacting to and coping with terminal dyspnea and delirium, answering questions about the dying process, dealing with family conflicts, communication concerning advance care planning, applicable PEOLC legislation, and managing the nurse's emotional impact are some areas to consider for future nursing education. As per the College of Nurses of Ontario (2019) competencies, learning opportunities should also include theory on the ethical, legal, regulatory, and personal self-care implications associated with PEOLC and medical assistance in dying (MAID) when providing nursing care.

The fourth recommendation supports nursing students becoming involved with nursing research as research participants. When completing the field notes, this researcher noted an awareness that participating in nursing research creates a level of curiosity, anxiety, and time management challenges for senior nursing students. At the same time, nursing students' voices can and should be heard in education and clinical practice research for the betterment of patient care and education; the importance of their voices cannot be understated. The opportunity to participate in research in their new role as advocates for patients, families, communities, and the profession, is an essential component in nursing education. Nursing students can bring a wealth of perspectives and greater understanding, and, as such, research participation should be emphasized and encouraged as they begin their socialization and journey within the profession. Since nursing students are extremely busy with their academic studies in a baccalaureate degree

program, in addition to being affected by the described social and national external factors which can have an impact on research participation rates, changes may need to be made within programs to enable research participation. These changes could include providing a course grade credit, mentorship opportunities, or certificate recognition. In this way, nursing students, researchers, academic institutions, the profession, and patient care receivers benefit from the research experience and contribution in the advancement of professional knowledge.

The fifth and final recommendation involves areas for potential future research. The literature and results of this study found that nursing students often experience an emotional impact when caring for patients and their families during end-of-life. Providing opportunities for students to understand their emotions and to foster emotional reasoning is recommended by Mayer and Cobb (2000). The authors also reinforced that further research is needed concerning emotional intelligence and educational practices (Mayer & Cobb, 2000). Further research is also recommended on the use and impact of varied and interactive education strategies such as arts-based expressions, high-fidelity simulation, and virtual reality/virtual patient learning as they relate to nursing students' self-efficacy and comfort for palliative and end-of-life care situations, along with the need to examine debriefing best practices in nursing education (Colley, 2016; Gannon et al., 2017; Maloney, 2012; Reierson et al., 2017). Using standardized tools and conducting well-designed experimental and quasi-experimental research to determine the impact of end-of-life education interventions on nursing students and patient care is also suggested by Carmack and Kemery (2017).

Conclusions

Safe and quality palliative and end-of-life care matters and nurses have a pivotal role in assisting patients and families achieve this outcome (Hold et al., 2014). The Quality End-of-Life Care Coalition of Canada (QELCCC, 2020) supports quality end-of-life care for all Canadians,

and has released their blueprint of action for 2020 to 2025. The QELCCC has identified four priorities with one priority focused on "ensuring [that] health providers, volunteers, communities, caregivers and others have access to education and training to ensure they possess the required competencies to provide optimal care" (p. 5). Research, such as this study, which contributes to the body of knowledge that prepares new baccalaureate nurses in providing optimal PEOLC, aligns with this priority.

Given this researcher's goal to contribute to quality PEOLC and nursing education, examining fourth-year baccalaureate nursing students' self-efficacy and emotional intelligence as it relates to their comfort when providing PEOLC for persons and their families was the purpose of this mixed-methods research study. The theoretical framework used for this research was Bandura's (1977) self-efficacy theory and Salovey and Mayer's (1990) emotional intelligence definition. Quantitative findings from this study showed there was evidence to suggest a statistically significant correlation between self-efficacy and comfort, as well as emotional intelligence and comfort of fourth-year nursing students in providing PEOLC for persons and families. The four themes from the qualitative phase included: previous experiences with PEOLC enhance comfort; need for PEOLC nursing education and teaching-learning strategies; emotional impact of providing PEOLC, and comfort level decreases with difficult PEOLC conversations and situations.

Interestingly, to provide nursing care to meet PEOLC needs (College of Nurses of Ontario, 2019), levels of self-efficacy can be positively influenced by education and instruction (Adriaansen & van Achterberg, 2004; Bandura, 1977; Phillips et al., 2011). Structured nursing education and nurse educators play an important role to ensure new graduates have achieved the required practice competencies and foundational level of comfort in delivering quality PEOLC to patients and their families (Corcoran, 2016). Nursing education has never been more important

as there are growing expectations that nursing students are comfortable and competent in providing quality PEOLC upon graduation in an ever-changing demographic, legislative, and healthcare environment.

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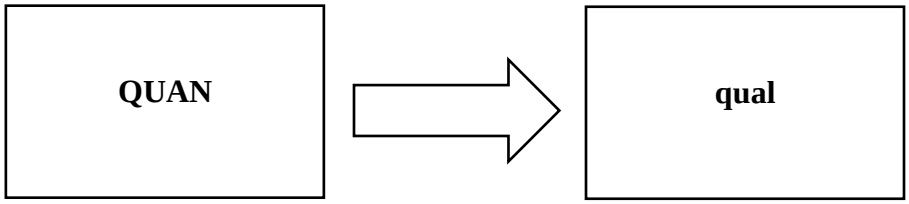
Appendix A

Sequential Explanatory Design



QUAN Data Collection ⇨ **QUAN** Data Analysis ⇨ **qual** Data Collection ⇨ **qual** Data Analysis ⇨ Interpretation of Entire Analysis

Reference: Adapted from Creswell, 2009.

Appendix B

Participation Invitation Letter

Forward to: Nursing Undergraduate Program Director (Collaborative Program)

Nursing Student Association president at York (nsay@my.yorku.ca)

Email: Fourth year York University Baccalaureate Nursing Students

Date: September 2021

Hello,

My name is Bev Beattie and I am a Doctoral Candidate in the Graduate Program in Nursing at York University in Toronto, Ontario. I am conducting a research project entitled: *Nursing Students' Comfort with Providing Palliative and End-of-Life Care.* This research project is part of my PhD program under the supervision of Dr. Mina Singh.

The purpose of this research is to explore fourth year baccalaureate nursing students' self-efficacy and emotional intelligence as it relates to their comfort in providing palliative and end-of-life care (PEOLC) for persons and their families. You have been invited to participate as fourth year nursing students in the York University collaborative baccalaureate program. The benefits that may be achieved through your voluntary participation is the opportunity for you to reflect and gain self-awareness and self-knowledge of an important area of nursing practice required upon graduation from the baccalaureate nursing degree program. In addition, involvement in the study may contribute to nursing education regarding senior baccalaureate nursing students' comfort in providing PEOLC for persons and their families. This information may assist in future curriculum planning and evaluation of palliative and end-of-life care-specific educational needs in nursing programs.

The mixed methods study begins with collecting quantitative data using three survey instruments, with an estimated time commitment of one (1) hour. Next, an invitation for six

participants to be involved in a focus group, with an estimated time commitment of one and a half hours (1.5), will follow to gain further understanding of fourth year baccalaureate nursing students' comfort with providing PEOLC. You may choose to only participate in the survey component. A separate consent will be requested for each part of the research that you choose to participate in.

If you are interested in being a participant in this research, or have any questions about the importance of the research and what it involves, please reply to this letter by email and I will arrange a date and time for us to discuss this opportunity further. My email address is beattie5@yorku.ca. Participant recruitment for this study will take place until the end of October, 2021.

Your interest in this study is very much appreciated!

Sincerely,

Bev Beattie RN, PhD (c)

Appendix C

Research Participant Consent Form- Surveys

Date: September 2021

Name of Participant: _____

Study Name: Nursing students' comfort with providing palliative and end-of-life care (PEOLC)

Researcher: Bev Beattie RN PhD (c)

Purpose of the Research: To explore fourth-year baccalaureate nursing students' self-efficacy and emotional intelligence as it relates to their comfort in providing PEOLC for persons and their families.

What You Will Be Asked to Do in the Research: You will be asked to complete the demographic data form and three survey instruments. The estimated time commitment for you will be one (1) hour.

i) End-of-life Professional Caregiver Survey,
ii) 33-Item Emotional Intelligence Scale,
iii) Palliative Care Self-Efficacy Scale.

Risks: As the researcher, I do not foresee any risks from your participation in the research. You have the right to not answer any questions.

Benefits of the Research and Benefits to You: The benefits that may be achieved through your voluntary participation is the opportunity for you to reflect and gain self-awareness and self-knowledge of an important area of nursing practice required upon graduation from the baccalaureate nursing degree program. In addition, involvement in the study may contribute to nursing education regarding senior baccalaureate nursing students' self-efficacy and emotional intelligence as it relates to their comfort in providing PEOLC for persons and their families. This information may assist in curriculum planning and evaluation of palliative and end-of-life care-specific educational needs in nursing programs.

Voluntary Participation: Your participation in the study is completely voluntary and you may choose to stop participating at any time. Your decision not to volunteer will not influence the nature of your relationship with York University either now, or in the future.

Withdrawal from the Study: You can stop participating in the study at any time, for any reason, if you so decide. Your decision to stop participating, or to refuse to answer particular questions, will not affect your relationship with the researcher, York University, or any other group associated with this project. In the event you withdraw from the study, all associated data collected will not be used in the research study.

Confidentiality: Unless you choose otherwise, all information you supply during the research will be held in confidence and unless you specifically indicate your consent, your name will not appear in any report or publication of the research.

The York University Qualtrics survey tool will be used for collecting the survey data. There is always a risk your responses may be intercepted by a third party (e.g., government agencies, hackers). Further, while York University researchers will not collect or use IP addresses or other information which could link your participation to your computer or electronic devices without informing you, there is a small risk with any platform such as this of data that is collected on external servers falling outside the control of the researcher. If you are concerned about this, I would be happy to make alternative arrangements (where possible) for you to participate, perhaps via telephone. Please contact beattie5@yorku.ca for further information.

All data collected by the survey instruments will be coded, thereby it will not be associated with identifying information. Your data will be safely stored in a password protected computer and locked filing cabinet, and only the principal investigator will have access to this information. The research data will be stored and retained for seven (7) years after the anticipated last action and it will be destroyed and deleted on September 1, 2029. Confidentiality will be provided to the fullest extent possible by law.

Questions About the Research? If you have questions about the research in general or about your role in the study, please feel free to contact Bev Beattie by email beattie5@yorku.ca. This research has been reviewed and approved by the FES Research Committee, on behalf of York University, and conforms to the standards of the Canadian Tri-Council Research Ethics guidelines. If you have any questions about this process, or about your rights as a participant in the study, please contact the Sr. Manager & Policy Advisor for the Office of Research Ethics, 5th Floor, Research Tower, York University (telephone 416-736-5914 or e-mail ore@yorku.ca.

Legal Rights and Signatures:

I,_____, consent to participate in the Nursing students' comfort with providing palliative and end-of-life care (PEOLC) study conducted by **Bev Beattie.**

I have understood the nature of the project and wish to participate. I am not waiving any of my legal rights by signing this form. My signature below indicates my consent.

Signature of Participant and Email	Date
Principal Investigator	Date

Focus Group Interview Participation:

Please include your name and email contact information below if you are interested in participating in a focus group of six persons to explore fourth year baccalaureate nursing students' comfort in providing PEOLC for persons and their families.

Name and Email Contact Information: _____

Reference: Adapted from Sample Informed Consent Form, York University

Appendix D

Research Participant Consent Form- Focus Group

Date: September 2021

Name of Participant: _____

Study Name: Nursing students' comfort with providing palliative and end-of-life care (PEOLC)

Researcher: Bev Beattie RN PhD (c)

Purpose of the Research: To explore fourth year baccalaureate nursing students' self-efficacy and emotional intelligence as it relates to their comfort in providing PEOLC for persons and their families.

What You Will Be Asked to Do in the Research: You will be asked to participate in a six-person focus group in which six questions will be posed to the group. The estimated time commitment for you will be one and a half hours (1.5 hrs.).

Risks: As the researcher, I do not foresee any risks from your participation in the research. You have the right to not answer any questions.

Benefits of the Research and Benefits to You: The benefits that may be achieved through your voluntary participation is the opportunity for you to reflect and gain self-awareness and self-knowledge of an important area of nursing practice required upon graduation from the baccalaureate nursing degree program. In addition, involvement in the study may contribute to nursing education regarding senior baccalaureate nursing students' self-efficacy and emotional intelligence as it relates to their comfort in providing PEOLC for persons and their families. This information may assist in curriculum planning and evaluation of palliative and end-of-life care-specific educational needs in nursing programs.

Voluntary Participation: Your participation in the study is completely voluntary and you may choose to stop participating at any time. Your decision not to volunteer will not influence the nature of your relationship with York University either now, or in the future.

Withdrawal from the Study: You can stop participating in the study at any time, for any reason, if you so decide. Your decision to stop participating, or to refuse to answer particular questions, will not affect your relationship with the researcher, York University, or any other group associated with this project. In the event you withdraw from the study, all associated data collected will not be used in the research study

Confidentiality: Unless you choose otherwise, all information you supply during the research will be held in confidence and unless you specifically indicate your consent, your name will not appear in any report or publication of the research.

This study will use Zoom to collect focus group data, which is an externally hosted cloud-based service. When information is transmitted over the internet privacy cannot be guaranteed. There is always a risk your responses may be intercepted by a third party (e.g., government agencies, hackers). Further, while York University researchers will not collect or use IP addresses or other information which could link your participation to your computer or electronic devices without informing you, there is a small risk with any platform such as this of data that is collected on external servers falling outside the control of the researcher. If you are concerned about this, I would be happy to make alternative arrangements (where possible) for you to participate, perhaps via telephone. Please contact beattie5@yorku.ca for further information.

The Philips audio recorder will be stored in a locked cabinet and the audio recording transcripts will be saved in a password protected file to the researcher's local computer, not the cloud-based service. Please note that it is the expectation that participants agree not to make any unauthorized recordings of the content of a meeting/ data collection session.

All data collected by the focus group will be coded, thereby it will not be associated with identifying information. Your data will be safely stored in a password protected computer and locked filing cabinet, and only the principal investigator will have access to this information. The research data will be stored and retained for seven (7) years after the anticipated last action and it will be destroyed and deleted on September 1, 2029. Confidentiality will be provided to the fullest extent possible by law.

Questions About the Research? If you have questions about the research in general or about your role in the study, please feel free to contact Bev Beattie by email beattie5@yorku.ca. This research has been reviewed and approved by the FES Research Committee, on behalf of York University, and conforms to the standards of the Canadian Tri-Council Research Ethics guidelines. If you have any questions about this process, or about your rights as a participant in the study, please contact the Sr. Manager & Policy Advisor for the Office of Research Ethics, 5th Floor, Research Tower, York University (telephone 416-736-5914 or e-mail ore@yorku.ca.

Legal Rights and Signatures:

I,_____, consent to participate in the Nursing students' comfort with providing palliative and end-of-life care (PEOLC) study conducted by **Bev Beattie.** This includes granting permission to the principal researcher, Bev Beattie, to audio record my voice during the focus group meeting.

I have understood the nature of the project and wish to participate. I am not waiving any of my legal rights by signing this form. My signature below indicates my consent.

Signature of Participant and Email	Date
Principal Investigator	Date

Reference: Adapted from Sample Informed Consent Form, York University

Appendix E

Demographic Data

The purpose of the mixed methods research study is to explore fourth-year baccalaureate nursing students' self-efficacy and emotional intelligence as it relates to their comfort in providing palliative and end-of-life care for persons and their families. Your feedback will be used to identify opportunities to evaluate and identify areas for opportunity in nursing education. Your participation is voluntary and completion of the three surveys and/ or participation in the focus group interview imply consent to participate. Confidentiality of your responses will be safeguarded. Thank you for your participation.

1. What is your age? _____

2. What is your gender? Male _____ Female _____ Gender Diverse _____

3. What is your ethnicity? _____

4. Do you consider yourself a spiritual person? Yes _____ No _____

5. Do you consider yourself a religious person? Yes _____ No _____

6. Are you in your final year of the nursing program? Yes _____ No _____

7. Have you taken core courses covering palliative and end-of-life care? Yes _____ No _____

8. Have you taken electives covering palliative and end-of-life care? Yes _____ No _____

9. Have any of your other courses covered the topic of palliative and end-of-life care?

10. Have you read books covering palliative and end-of-life care? Yes _____ No _____

11. Do you have any previous experience with end-of-life involving a pet?

    Yes _____ No _____

12. Do you have any previous experience providing palliative and end-of-life care for a terminally ill family member, loved one, or friend?

    Yes _____ No _____

13. Do you have any previous experience providing palliative and end-of-life care for an assigned patient as a student or healthcare worker?

Yes _____ No _____

14. Do you have any previous experience with persons requesting medical assistance in dying (MAID)?

Yes _____ No _____

Appendix F

Palliative Care Self-Efficacy Scale

Items	(1) Need further basic instruction	(2) Confident to perform with close supervision /coaching	(3) Confident to perform with minimal consultation	(4) Confident to perform independently
1. Answering patient's questions about the dying process.				
2. Supporting the patient or family member when they become upset.				
3. Informing people of the support services available.				
4. Discussing different environmental options (e.g. hospital, home, family).				
5. Discussing patient's wishes for after their death.				
6. Answering queries about the effects of certain medications.				
7. Reacting to reports of pain from the patient.				
8. Reacting to and coping with terminal delirium.				
9. Reacting to and coping with terminal dyspnea (breathlessness).				
10. Reacting to and coping with nausea/vomiting.				
11. Reacting to and coping with reports of constipation.				
12. Reacting to and coping with limited patient decision-making capacity.				

Reference: Phillips, Salamonson, & Davidson, 2011.

Appendix G

End of Life Professional Caregiver Survey					
	Not at All 0	**A Little Bit 1**	**Somewhat 2**	**Quite a Bit 3**	**Very Much 4**
1. I am comfortable helping families to accept a poor prognosis.	0	1	2	3	4
2. I am able to set goals for care with patients and families.	0	1	2	3	4
3. I am comfortable talking to patients and families about personal choice and self-determination.	0	1	2	3	4
4. I am comfortable starting and participating in discussions about code status.	0	1	2	3	4
5. I can assist family members and others through the grieving process.	0	1	2	3	4
6. I am able to document the needs and interventions of my patients.	0	1	2	3	4
7. I am comfortable talking with other health care professionals about the care of dying patients.	0	1	2	3	4
8. I am comfortable helping to resolve difficult family conflicts about end-of-life care.	0	1	2	3	4
9. I can recognize impending death (physiologic changes).	0	1	2	3	4
10. I know how to use non-drug therapies in management of patient's symptoms.	0	1	2	3	4
11. I am able to address patient's and family members' fears of getting addicted to pain medications.	0	1	2	3	4
12. I encourage patients and families to complete advance care planning.	0	1	2	3	4
13. I am comfortable dealing with ethical issues related to end-of-life/ hospice/ palliative care.	0	1	2	3	4
14. I am able to deal with my feelings related to working with dying patients.	0	1	2	3	4
15. I am able to be present with dying patients.	0	1	2	3	4
16. I can address spiritual issues with patients and their families.	0	1	2	3	4

17. I am comfortable dealing with patients' and families' religious and cultural perspectives.	0	1	2	3	4
18. I am comfortable providing grief counseling for families.	0	1	2	3	4
19. I am comfortable providing grief counseling for staff.	0	1	2	3	4
20. I am knowledgeable about cultural factors influencing end-of-life care.	0	1	2	3	4
21. I can recognize when patients are appropriate for referral to hospice.	0	1	2	3	4
22. I am familiar with palliative care principles and national guidelines.	0	1	2	3	4
23. I am effective at helping patients and families navigate the health care system.	0	1	2	3	4
24. I am familiar with the services hospice provides.	0	1	2	3	4
25. I am effective at helping to maintain continuity across care settings.	0	1	2	3	4
26. I feel comfortable addressing requests for ~~assisted suicide~~ medical assistance in dying (MAiD).	0	1	2	3	4
27. I have personal resources to help meet my needs when working with dying patients and families.	0	1	2	3	4
28. I feel that my workplace provides resources to support staff who care for dying patients.	0	1	2	3	4

Reference: Lazenby, Ercolano, Schulman-Green, & McCorkle, 2012.

Appendix H

33-Item Emotional Intelligence Scale					
Items	**Strongly Disagree** 1	**Disagree** **2**	**Neither Disagree or Agree** **3**	**Agree** **4**	**Strongly Agree** **5**
1. I know when to speak about my personal problems to others.	1	2	3	4	5
2. When I am faced with obstacles, I remember times I faced similar obstacles and overcame them.	1	2	3	4	5
3. I expect that I will do well on most things I try.	1	2	3	4	5
4. Other people find it easy to confide in me.	1	2	3	4	5
5. I find it hard to understand the non-verbal messages of other people*	1	2	3	4	5
6. Some of the major events of my life have led me to re-evaluate what is important and not important.	1	2	3	4	5
7. When my mood changes, I see new possibilities.	1	2	3	4	5
8. Emotions are one of the things that make life worth living.	1	2	3	4	5
9. I am aware of my emotions as I experience them.	1	2	3	4	5
10. I expect good things to happen.	1	2	3	4	5
11. I like to share my emotions with others.	1	2	3	4	5
12. When I experience a positive emotion, I know how to make it last.	1	2	3	4	5
13. I arrange events others enjoy.	1	2	3	4	5
14. I seek out activities that make me happy.	1	2	3	4	5
15. I am aware of the non-verbal messages I send to others.	1	2	3	4	5
16. I present myself in a way that makes a good impression on others.	1	2	3	4	5
17. When I am in a positive mood, solving problems is easy for me.	1	2	3	4	5

18. By looking at their facial expressions, I recognize the emotions people are experiencing.	1	2	3	4	5
19. I know why my emotions change.	1	2	3	4	5
20. When I am in a positive mood, I am able to come up with new ideas.	1	2	3	4	5
21. I have control over my emotions.	1	2	3	4	5
22. I easily recognize my emotions as I experience them.	1	2	3	4	5
23. I motivate myself by imagining a good outcome to tasks I take on.	1	2	3	4	5
24. I compliment others when they have done something well.	1	2	3	4	5
25. I am aware of the non-verbal messages other people send.	1	2	3	4	5
26. When another person tells me about an important event in his or her life, I almost feel as though I have experienced this event myself.	1	2	3	4	5
27. When I feel a change in emotions, I tend to come up with new ideas.	1	2	3	4	5
28. When I am faced with a challenge, I give up because I believe I will fail*	1	2	3	4	5
29. I know what other people are feeling just by looking at them.	1	2	3	4	5
30. I help other people feel better when they are down.	1	2	3	4	5
31. I use good moods to help myself keep trying in the face of obstacles.	1	2	3	4	5
32. I can tell how people are feeling by listening to the tone of their voice.	1	2	3	4	5
33. It is difficult for me to understand why people feel the way they do*	1	2	3	4	5
"Note: The authors permit free use of the scale for research and clinical purposes" (p. 172). *These items are reverse scored.					

Reference: Schutte, Malouff, Hall, Haggerty, Cooper, Golden, & Dornheim, 1998.

Appendix I

Qualitative Interview Questions

Good morning; Thank you for taking the time to participate in the mixed methods research study which explores the perspectives of fourth-year baccalaureate nursing students' self-efficacy and emotional intelligence as it relates to their comfort in providing palliative and end-of-life care (PEOLC) for persons and their families.

This interview will be audio-tape recorded with the information obtained being kept confidential and stored in a secure setting. Please feel free at any time to ask for clarification of a question and/ or to decline answering a question.

Qualitative Questions:

1. Emotional response – How would you describe your ability to assess, regulate, and use your emotions to problem solve situations when providing palliative and end-of-life care for persons and their families?
2. Self-Efficacy – How would you describe your level of ability to react, answer questions, and provide palliative and end-of-life care for persons and their families?
3. Comfort- How comfortable are you with providing palliative and end-of-life care to persons and families?
4. Previous experiences- How have your previous life, education and/or work experiences impacted this comfort level?
5. MAiD- How will the ongoing changes in legislation involving medical assistance in dying (MAiD) impact your comfort when providing palliative and end-of-life care in your own nursing practice?
6. Nursing Education- How prepared do you feel to provide holistic PEOLC now that you are in your 4th year of your baccalaureate education? How can baccalaureate nursing degree programs better prepare nursing students to be comfortable in providing palliative and end-of-life care for persons and their families?

Thank you.

Appendix J

Post Interview Field Notes Template

Describe the interview process: - Describe the physical context. - How did it go? -How comfortable did your participants seem? -How comfortable were you? -Describe the rhythms of the interview: how long did it take to break the ice? -Were there interruptions, breaks? -How did they affect the interview process?	**Post- Interview Field Notes**
Synthesize the content of the interview. -Try to summarize the content of the interview. -What seems especially striking to you? -What seems to stand out compared to other interviews?	
Reflect on how you conducted the interview. -As an interviewer, what were your strengths and weaknesses? -What would you change for the next interview?	
Analytical remarks. -How does the content of the interview confirm or contradict the results of previous studies on the topic? -How does the content of the interview confirm or contradict the quantitative findings? -Do you see links with your conceptual constructs and the interview? -What interpretive insights does this interview generate?	

Adapted from Gaudet and Robert, 2018, p. 105.

Appendix K

Definitions

Advance Care Planning: "Is a process of reflection and communication. It is a time for you to reflect on your values and wishes, and to let people know what kind of health and personal care you would want in the future if you were unable to speak for yourself" (Advance Care Planning Canada, 2023, para. 1).

Comfort: "(or being comfortable) is a sense of physical or psychological ease… persons who are lacking in comfort are uncomfortable, or experiencing discomfort" (Wikipedia, 2022, para 1).

Emotional Intelligence: "the ability to monitor one's own and others' feelings and emotions, to discriminate among them, and to use this information to guide one's thinking and actions" (Salovey & Mayer, 1990, p. 189).

End-of-life care- "Care given to people who are near the end of life and have stopped treatment to cure or control their disease. End-of-life care includes physical, emotional, social, and spiritual support for patients and their families" (National Cancer Institute, 2022, para. 1).

Medical assistance in dying (MAID)- "The term Medical Assistance in Dying, describes:

a. the administering by a physician or nurse practitioner of a substance to a person, at their request, that causes their death; or
b. the prescribing or providing by a physician or nurse practitioner of a substance to a person at their request, so that they may self-administer the substance and in doing so cause their own death" (Ontario Ministry of Health and Long-Term Care, 2023, para. 7).

Palliative care- "Palliative care refers to care for patients and their families who are facing a serious, life-limiting illness. Palliative care is patient-centred coordinated care that aims to relieve suffering and improve quality of life for patients and their families at all stages of the illness" (Ontario Ministry of Health and Long- Term Care, 2021, para. 1).

Self-efficacy: Self-efficacy is defined as a person's perceived capability to perform and influence events that impact their lives (Bandura 1994). The beliefs associated with self-efficacy will then determine how a person feels, thinks, and is motivated to behave in a situation (Bandura, 1994).

Appendix L

Poem titled: "Nursing Education on Loss and Grief"

The time has come for us to teach,
The concepts of death, dying, loss and grief.
Where do we begin with so much to cover,
And all that there is to fully discover?
Knowledge, competencies, and skills aplenty,
Including dignity, relational caring and serenity.
Grieving and nursing theories to guide practice and care,
To support the persons and families that bear,
The sadness and grief of a loved one's death,
Enabling them to continue with their own breath.
A caring and empathic approach and touch,
Have a significant impact and mean so much.
Take time for mindfulness and personal self-care,
To ensure you have the energy to spare.
Continually learn in your nursing career,
And dreams, goals, and wonders will appear.

Written by Bev Beattie, July 16, 2019.