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Nursing students experiences of end-of-life care

Kerry Jones, Jan Draper and Nerys Boulton

Abstract

Background: Undergraduate nursing students spend a significant amount of time in clinical placements where they are involved in care at the end of a person's life and care after death. While their role is to provide compassionate care, some students feel wholly unprepared. **Aims:** The aim of this qualitative study was to explore student nurses' experiences of care in death, dying and post death care, and to explore how students can be better prepared to provide such care. **Methods:** This is a qualitative descriptive study that is concerned with the subjective reality of participant's experiences. **Findings:** Six themes were developed from the analysis: first encounters with death and dying; preparedness; mentoring and support received; the caring role; striving to cope; working with families and working through COVID-19. **Conclusion:** Students described their experience of placements in end-of-life care as challenging, yet were also able to adopt ways to develop as compassionate practitioners.

Key words: ● end-of-life care ● education ● nursing students ● mentoring ● palliative care

Nurses and undergraduate nursing students spend the largest amount of time with a dying patient and their family out of the healthcare team involved in their care. They are frequently the staff members who perform the care after death and post death care of a patient (Ramjan et al, 2010; Razban et al, 2013; Leombruni et al, 2014). The International Council of Nurses (2012) stresses that the nurses' role is important when caring for dying patients, as this role improves the quality of life for patients and their families in the management of physical, social, psychological, spiritual and cultural needs (International Council of Nurses, 2012).

Nurses play an important role in developing a caring and supportive environment that acknowledges death to help family members to accept and deal with loss and grief (Gül et al, 2020; Goldbold et al, 2021). Nurses therefore have a critical role in caring for this group of patients (Cunningham et al, 2006; Rosdahl and Kowalski, 2012). However, this part of nursing care can be challenging and emotionally distressing, and some members of the healthcare team may feel unprepared to provide such care (Mok et al, 2002; Birkholtz et al, 2004; Mutto et al, 2010; Wang et al, 2016; Ranse et al, 2018). Moreover, several studies suggest that there is only low- to – moderate student knowledge of

palliative care (Bratjman et al, 2007; Al Qadire, 2014; Khraisat et al, 2017). Formal education, such as simulation of end-of-life care settings, clinical experience and adequate support like mentoring, can assist student nurses to develop confidence, skills and knowledge, in the provision of care and the end of life and to enable them to be physically, emotionally and spiritually present for patients and their families (Huang et al, 2010; Kent et al, 2012; Adesina et al, 2014; Edo-Gual et al, 2014; Ek et al, 2014; Bassa et al, 2016; Smith et al, 2018).

However, undergraduate nurse education has traditionally had a limited focus on palliative and end-of-life care, that suggests that undergraduate nursing curricula are inadequate (Cavaye and Watts, 2014). Without an adequate level of training in care of the dying patient, student nurses called to work with patients close to death can develop greater death anxiety, feelings of impotence and a negative approach to care (Mallory, 2003; Alchin et al, 2006; Terry et al, 2008; Parry, 2011; Heise et al, 2016; Galvin et al, 2020;).

Moreover, end-of-life care is delivered across different institutional settings, including in hospitals, hospices and care homes, and in environments where student nurses are likely to undertake their placement. Yet, there is considerable evidence that a proportion of

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individuals in receipt of such care in a hospital setting would experience better care elsewhere, such as at home or in a hospice, since hospitals are not necessarily the best place for symptom management. In turn, this can impact on nursing students who may feel better equipped to provide care to individuals at the end of life in some institutional settings compared to others (Hunter and Olovic, 2018).

Attitudes toward end-of-life care are also an important factor of nurses and student nurses who are responsible for caring for terminally ill patients (Sanford et al, 2011; Razban et al, 2013; Straughair, 2019). Several studies have assessed nurses' attitude to providing care at the end-of-life (Sadala and Da Silva, 2009; Razban et al, 2013; Leombruni et al, 2020). Indeed, Razban et al (2013) examined the attitude toward palliative care of two groups of Iranian nurses who worked either in oncology or intensive care in Southeast Iran. Their findings reveal the difficulties felt by these nurses in providing end-of-life care as the nurses in the study reported moderately negative to neutral attitudes toward palliative care.

A further Iranian study (Shahrki et al, 2018) focused on 25 nursing home staff and ten nursing home residents and found that training staff about the cultural needs of residents was the most effective way to improve care and the experiences of nursing home residents at the end stage of life.

In another study conducted in Brazil with fourteen undergraduate nursing students, Sadala and da Silva (2009) explored how students perceived their care of patients diagnosed with cancer. The findings demonstrate that students found this to be a painful experience and led them to confront their own insecurities. Such insecurity was felt due to a lack of preparation and inexperience, as well as a lack of support from other staff during their practical placement (Sadala and da Silva, 2009). Similarly, Leombruni et al (2014) examined Italian nursing students' attitudes towards caring for dying patients using the Frommelt Attitude Toward Care of the Dying (FATCOD-B) scale. They reported that nursing students in Italy needed more end-of life care education to help them to be better prepared.

Other recent studies have focused on the impact on nursing students of the COVID-19 global pandemic. Research in this area is in its infancy, and thus, results are only just emerging. But findings indicate it is likely that nursing students are experiencing significant levels of emotional distress that are exacerbated by several factors. These include staff shortages, a

lack of clinical guidelines, longer working hours, unpredictability concerning the timescale of the pandemic, risk of personal illness or death and the scale of disease and death encountered (Galvin et al, 2020; Jackson et al, 2020; Smith et al, 2020).

It is essential that students caring for dying patients are well prepared for the role, including prior training and mentorship. To become a registered nurse (RN) in the UK, students have to complete a 3-year nursing degree programme with the Approved Educational Institution (AEI) as endorsed by the UK Nursing and Midwifery Council. The entry requirements onto AEI UK nursing degree programmes include successful attainment of Access to Nursing; Pearson BTEC Level 3 Diploma qualifications; Scottish Highers/Advanced Highers; QCR Cambridge Technical, and International Baccalaureate (IB).

While the study reported here was conceived and designed prior to the pandemic, the authors have endeavoured to include students' experiences of working with patients affected by COVID-19 in the UK and who are enrolled on The Open University nursing degree programme.

Aims

Considering the importance of end stage care, this research aimed to explore the experience of caring of end stage patients by nursing students and how students can be prepared to provide such care.

Methods

This study used an explorative qualitative approach to determine the experiences of student nurses caring for dying patients using semi-structured interviews and thematic analysis.

Participants

A purposive sampling method was used. These students were registered on The Open University 3-year nursing degree programme, which is a UK Nursing and Midwifery Council AEI. Students on the nursing programme would have had very little or no training about caring for patients at the end stage of life, instead relying on placements to 'learn on the job.'

Students eligible for participation were:

- Enrolled on the undergraduate nursing programme at The Open University
- The inclusion criteria included students who were working in placements involving end-of-life care
- Those who were not eligible to participate were students who had not had clinical exposure to working in end-of-life care as part

of their placement.

Purposive sampling was used. For example, in agreement with course tutors, authors introduced the study through classes for each cohort (one in the North East of England, one in the South West of England). The tutors delivered participant information which detailed the purpose and procedures of the study, and participation was entirely voluntary and anonymous. Participants had the right to withdraw.

Out of the fifteen of the initial fifteen students who expressed an interest to participate, four dropped out prior to interview with no reason was given. Nevertheless, data saturation was reached with eleven participants without the need for further recruitment. Of nursing students in their first year, four took part in this study, while four were in their second year and three were in their third and final year of the nursing programme.

The authors aimed to explore undergraduate nurses experience and who had clinical exposure to death, dying and managing a dead body.

Rigour

Guba and Lincoln's (1982) criteria was adapted and relevant strategies were applied to the study. The interview schedule was piloted with colleagues, and established investigator's authority, such that the research team had the research experience and skills to perform the role. One of the authors is an academic researcher and experienced in conducting sensitive research among clinicians in end-of-life care, while two were clinicians and one a clinician and educator by background. The first author was able to limit and check for biases by interrogating interview transcripts to ensure that interview topics and responses to participant interviews adhered to the research schedule. Moreover, the authors were able to reduce the potential for bias by using a gatekeeper for recruitment and not any of the research team.

All three authors conducted interviews separately. Data was transcribed by an independent transcription service. Transcripts from interviews were compared for triangulation of data. The authors also completed reflexive journals and held weekly investigator meetings. Given the authors' backgrounds we recognised the potential for bias, and responses to interviews in the journal were noted and discussed against that of the interview schedule and subsequent emergent themes to ensure they were relevant to the transcription data.

Consolidated criteria for reporting qualitative

research (COREQ) (Tong et al, 2007) was undertaken.

Ethical considerations

Ethical considerations in this study were guided by the Royal College of Nursing (2011) principles of conducting ethical research. The ethically sensitive nature of this study, as well as the challenges of conducting research during a pandemic were recognised (including changing from face-to-face encounters to online), as well as the potential for strong emotions to emerge. An opportunity to reflect on student emotions and responses during interviews was offered to students on completion of interviews with an additional check on their welfare (via text, email or phone) in the days following interviews.

None of the students undertook this offer. Approval by the authors' university ethics committee was sought, initially to conduct face-to-face focus groups, that were subsequently changed to Skype interviews to reflect the social distancing measures during the pandemic. Approval from the ethics committee was granted (Human Research Ethics Committee 3538). Students were given participant information sheets which reassured anonymity and the right to withdraw at any time, as well as the opportunity to clarify any questions or concerns and provided verbal as well as written informed consent.

Participants who took part in interviews would only be identifiable after consent has been sought. All identifiable personal data will then be removed and a unique code attached. A digitised copy of the consent form is stored using the participants code and the paper copy was securely destroyed. All anonymised interview data was stored electronically on the authors institutional One Drive (enabled with file vault for encryption and password protected as well as firewall as well, Bit locker and Advanced Encryption Standard).

Interviews

Due to the COVID-19 pandemic, data were collected via semi-structured interviews conducted through Skype (rather than face-to-face) by the authors (KJ, JD, NB) all three of whom are highly experienced in conducting research interviews. Participants joined the Skype interview from their home alone. Each interview took between 45 and 60 minutes. The focus was on the students' experience of death, dying and managing a dead body, including performing last offices. To ensure consistency in interview technique an interview guide was developed

comprising seven areas:

- The emotional impact (early and subsequent) experience of working in end-of-life care
- Levels of support and mentoring received
- Training and education needs
- Caring for others
- Relationships with patients and families
- Coping with working in end-of-life care settings
- Challenges of care due to COVID-19
- Interviews were transcribed verbatim.

Analysis

The data from interviews were analysed using thematic analysis (van Manen, 1997). This study adopted van Manen's hermeneutic phenomenological approach, as it is especially relevant to nursing research and provided a way to understand how students experience their care of patients at the end stage of life. This approach comprised of four steps of data analysis that enabled the texts to be scrutinised in order to develop the structure of meaning of the texts or themes. The process involved (1) uncovering thematic aspects, (2) isolating thematic statements, (3) composing linguistic transformations, and (4) gleaning thematic descriptions.

A guiding principle throughout analysis was to understand the meaning of students experiences in end-of-life care and to obtain knowledge which would better prepare students to care for patients at the end stages of life. One author (KJ) carried out the analysis and themes were discussed with the other two authors (JD, NB) until consensus was reached.

Results

Seven themes were generated from the data analysed as shown in *Table 1*.

First encounters with death and dying

Many of the participants described their emotions concerning their early encounters with death and dying. Many felt completely unprepared about both the emotional impacts and the physiological changes in the dying person and during post death care:

'And I have to be honest to say that I don't think I was very prepared for what I was going to see. Not necessarily as far as the emotional side and how I felt, but just about the actual physical side of what happens to somebody when they are dying, especially in those final stages. So that was quite a shock the first time.' (Participant 8, year of study, 3)

Some were able to vividly recall their first encounter and some of the younger students described how these first encounters were 'daunting.'

A first-year student recalled her first experiences of death when she was caring for a two-week old baby:

'So, my very first dealings was I worked with end-of-life children, and it was a little baby who was 2 weeks old who had a brain haemorrhage and died and bled out in my arms. So that was very hard. I sort of went numb like I didn't know how to feel, I didn't know how to like switch on or switch off or what to do in that situation as my very first death.' (Participant 11, year of study, 1)

These students during interviews also recollected that had they had little or no prior awareness about what to expect at the end stage of a patient's life and that had deleterious consequences for their emotional wellbeing at the time.

Support vs no support

While caring for the dying can be a rewarding experience it can also be emotionally demanding, and students require support and mentoring from clinical nurses. Some respondents did feel supported, and this helped to mitigate against feelings of isolation, especially when they felt in a position to ask questions related to concerns, for example, queries they might have had about caring for a dying patient. As a result, they felt a valued member of the nursing team. One respondent whose practice placement was in a hospice felt they were very well supported:

'At the hospice we really do talk to each other. We have a lot of, you know, there's often colleagues in tears, and we really do support each other. We do have ward managers, as well, that we could go to. I know that their door's always open if you had really struggled. We're very good at supporting each other, definitely doctors and colleagues as and when we need it.' (Participant 3, year of study, 3)

The level of support was further enhanced by mentoring from university tutors:

'The trust (hospital trust) in which I work in has been very good by offering support, also through the University with my practice tutors, they've been brilliant as well, in coming to terms and dealing with all that really'.

(Participant 10, year of study, 2)

However, while some respondents had good support and mentoring, some students felt that this support was lacking. In some instances, the more experienced nursing students such as those in their final year of study and placement were assumed by other senior staff to be able to take on aspects of a qualified nursing role, for example in verifying a death. Where there was a lack of support, some respondents felt the need to turn to their fellow students or partners after a shift:

‘I briefly spoke about it, I think with other students and, to be honest, most of the support came from my partner when I came home, so obviously I maintained confidentiality, but I just explained the situation and said that I was sad and, again, on the ward there was no debrief or anything like that and as soon as the body got taken off it was business as usual, nobody else really seemed that fussed, to be honest, nobody took a moment to digest it or anything like that.’ (Participant 2, year of study, 1).

It is evident from these accounts that high quality support and mentoring is valued by nursing students, and this helps them to handle the emotional challenges of death and dying while on clinical placement. Good mentoring and support are important at any time, but during the COVID-19 pandemic, it is especially key given the additional challenges nursing students face during their placements at this time.

Preparedness: the role of education and on the job training

All respondents felt unprepared in some aspect of their role in caring for patients who were dying and post death care of a dead patient, and identified how education and training could help to mitigate experiences of unpreparedness:

‘Particularly when somebody’s breathing alters or before you can move a body and there might be sounds, burp or wind, to prepare somebody. Because somebody might not realise that that can happen, that might really freak somebody out.’ (Participant 9, year of study, 1).

Another respondent identified their training needs and felt they could benefit from on-the-job training to gain clinical experience of how to care for a patient after death:

‘I want to go to the mortuary, you see, and see

what they do in there, because I feel like I just need to know. I want to know what it looks like; I want to know what they do. I want to know how they behave; I want to know how they move and handle people. I want to know what they do with the body afterwards and, I just want to know the whole process.’ (Participant 9, year of study 1).

While exposure to patients’ bodies and associated processes is identified as a training need for this respondent, other students suggested that palliative and end-of-life care training should be compulsory to help students to be better prepared.

The caring role

Many of the students talked about the privilege of caring for someone at the end of life, doing personal care and being one of the last people to be with someone:

‘Certainly, when I worked in a hospice, I felt an overwhelming feeling of privilege. I know there was one particular case where I was with the patient washing, and just feeling what a privilege to be doing that and then I noticed that she was passing. I just remember thinking how fortunate I was to have been the person that was able to give her a wash and that would be the last thing that was done for her.’ (Participant 8, year of study, 3).

Some of the students talked about the support given to the families when either death was imminent or just after death. One described how she always sought to treat people the way she would want to be treated, and another talked about how her own personal experience of death and dying meant that:

‘I’ve been in their shoes, not totally the same, but having someone pass away, yeah, you do see it from their side, yeah.’ (Participant, 4 year of study, 1).

In caring for others in this way, students derived a sense of satisfaction in caring for others as part of their student placement.

Working with families

For some of the participants, the process of death and dying had a significant impact on relationships they established with the clients and their families. This then went on to have an impact on how they felt as students when the patient died:

‘So you really build up a relationship with the family as well. And, it’s really nice to have them on board and they know the work that you’re doing, the reasons why we’re doing it, and the rationale for what we’re doing to make their end of life really comfortable.’ (Participant 3, year of study, 3).

While relationships with families brought about good practice, some students found working with families emotionally challenging, especially when a patient had died:

‘I was nearly crying on the phone, it was, but obviously, you’ve got to remain professional, but you build a rapport up and you build a relationship with obviously the person you’re looking after, so for them then to obviously pass away and stuff, and his wife she was lovely, she was chatty ... she’d bake and stuff for us, so she was like a family, you know what I mean, so we’d built up that relationship with her. (Participant 5, year of study, 2).

While most students described the emotional ramifications of caring for patients and families at the end of life, they also felt privileged in being present at a critical time at the end of a patient’s life.

Striving to cope

Students described caring for the dying patient and their family as being a particularly stressful part of their role and one which can be emotionally taxing. In order to manage their emotions student nurses adopted varying coping strategies. Some students felt able to cope by adopting a level of detachment while also being reassured that a patient’s needs were being met:

‘I feel that what’s helped me is that I always remind myself that the patient’s not in pain anymore. Some of them, that’s what they wanted, they wanted to die. That’s where I got the emotion of relief. I know there’s many variables to death and dying, but sometimes they just bring back little memories of my own family, but I always remember to detach myself from that when I’m with the patient and then when I go home think about it and then, not get over it, but try not to think about it again.’ (Participant 1, year of study, 2).

The findings from the interviews also suggest that, for some participants, being exposed to death and dying enhanced their perceived ability to cope by enabling feelings

to emerge and engage in reflective practice:

‘Yeah, definitely got that thicker skin that I needed. Even though you cry and you let out your emotions, in that time you’re there and you’re the support of the families of the resident and you do your job role, and then you sort of reflect on everything else. So every death that we’ve had, I’ve had to do like a reflection on it and just to let it out a little bit, just to, OK, that person was here, we’ve made them comfortable, we’ve done everything I possibly could to keep them comfortable, keep them dignified and I’ve supported their family so I think I’ve done a job well done.’ (Participant 11, year of study, 1).

While these students described adopting detachment and resilience coping mechanisms, they did so in the knowledge that they had performed well in their role caring for a patient at the end of life.

Working through COVID-19

At the time the interviews took place, nursing students were undertaking placements (hospitals, hospices, inpatient clinics, GP surgeries) during the COVID-19 pandemic. Many were to experience additional challenges due to increases in patient deaths and witnessing distress during dying. Participants felt they were providing what they felt was less-optimal care, since personal protective equipment (PPE) meant they were not able to provide as much reassurance to a dying patient, such as a smile, or personal touch such as holding a hand. Some students felt a range of emotions including sadness:

‘I felt incredibly sad that they weren’t able to see a human face or have a human touch. This particular patient did have COVID-19. I knew that the last thing they were going to see was a masked face and a gloved hand and an apron, it doesn’t feel very comforting, it doesn’t feel very loving, it feels very clinical and not very personal.’ (Participant 2, year of study, 1).

This respondent also expressed sadness for dying patient’s families as they would not have the opportunity to say goodbye or hold a dying relative’s hand which would impact on their grief. Moreover, this respondent also noted that relatives could be unprepared for the rapid deterioration in a relative infected with COVID-19.

Similarly, another respondent reflected with sadness on deaths and how this has

impacted on grieving relatives during the COVID-19 pandemic:

‘It’s been a very upsetting process through COVID-19 because of all of the different situations that people have had to face. You know, little ladies that have been married to their husbands for 50, 60, 70 years, and weren’t able to be with them as they died because of restraints on visiting. So, you had a whole other aspect of the whole dying process because we were supporting somebody that is grieving the loss of being able to say goodbye.’ (Participant 8, year of study, 3).

While nursing students found caring for Covid-19 infected patients and deaths a challenge that emits sadness and anger, it also enabled them to develop as compassionate practitioners. Whether this can be taught, or is inherent, is debated elsewhere in the literature (Straughair, 2019). Education and training, however, has a crucial part in preparing student nurses to work with the death, dying and the dead body.

Discussion and recommendations for practice

Caring for a dying patient and their family, emotionally and physically featured in the students’ narrative of their end-of-life experiences in this study. While student nurses were distressed by death and dying encounters especially earlier on in their nursing training and clinical placement, this nursing student sample held predominantly positive attitudes towards care at the end-of-life, citing it as a privilege. This is despite gaps in knowledge and training in palliative care. While there was a focus on situations of expected death, it emerged through interviews that while this was a death that was expected to be imminent, it still caused significant distress among students first experiences of death, and this could impact on their mental health.

Such distress was mitigated by the presence of role models, such as mentors and senior colleagues, and in environments where open discussion of distressing events was encouraged, facilitated, and permitted. This occurred in both hospital and hospice settings and this indicates the presence of empathic staff.

The absence of mentors had a debilitating impact on those students who felt they received little support or opportunity to emotionally process events with colleagues, especially in hospitals, despite the more positive experiences of one their peers. This could be indicative of

the nature of caring for patients in a hospital environment that is likely to be less specialised in terms of end-of-life care (Hunter and Olivio, 2018).

Instead, a feature of such narratives was the need to turn to their own family albeit in confidence to process a death event. A wide body of literature cites the importance of building collegiate and professional relationships and support networks within the wider context of developing resilience and helping students to be better prepared (Birkholtz et al, 2004; Edo-Gual et al, 2014; Sadala and Da Silva, 2019).

A lack of prior experience of death and dying either personally, or in a clinical environment, was a significant moderator of preparedness to perform last rites, and to be aware of changes after death, such as sounds emitting from a deceased person. The responses of nursing students to their role in after death care in this study were consistent with the findings of Leombruni’s (2014) study that identified that advanced knowledge of post-mortem care could be consolidated through the nursing curriculum and training in clinical placement.

Indeed, a recurrent theme to emerge from interviews was the need for on-the-job training, for example spending time in the morgue to become familiar with last offices and physical post death changes in the body, a similar finding of Anon et al’s (2020) review of nurses and undergraduate nurses experiences of death and dying. These findings indicate a need for greater preparation of nursing students for the experience of observing a patient dying and their body post-death.

Participants in this study described their experience as caring for the patient, as well as the family. Several students described being present either physically in the room or through touch with a patient. Several narrative accounts at the end-of-life implied that this was a privilege, particularly, when they had come to spend time and to know the patient and their family. While the provision of care to a dying patient and their family was highly valued by students, they felt a deep sense of loss especially in dealing with distressed families, in keeping with other studies (Kent et al, 2012; Ranse et al, 2018)

While nursing students in this study clearly felt that caring for patients and families at the end of life was a privilege, the emotional toll of caring for dying patients and hence coping also emerged. Indeed, in this study, several nursing students recounted experiences of attempting to suppress their emotions, even though they were moved by deaths of patients. In keeping with

other studies (Alchin et al, 2006; Cunningham et al, 2006; Edo-Gual, 2014), emotional suppression appeared to be an emotional response rather than the adoption of a coping strategy by student nurses. Rather, detachment as a coping strategy and knowing that they provided optimal care for a dying patient. Other nursing students in this study were able to adopt a level of detachment as a coping mechanism having reflected on the optimal care that they had provided.

Yet, while nurses were able to reflexively account on their experiences and be reassured by their provision of high-quality end-of-life care, the COVID-19 pandemic has presented unique challenges to nursing student's caring role.

During the pandemic, more experienced students, such as those in their third and final year were expected to take on tasks usually associated with qualified nurses. This was more apparent during the COVID-19 pandemic in 2021 due to the additional challenges of trying to replace staff who were off sick. As with health professionals in end-of-life care, nursing students too faced the additional challenges of shortages of protective equipment, lack of provision of personal care (i.e. lack of a smile due to masks), unpredictability of the scale of the pandemic, fear of personal illness and death. This is similarly noted by several other studies (Galvin et al, 2020; Jackson et al, 2020; Smith et al, 2020; Gobold et al, 2021). However, it was also noted that such experiences gained during such an unprecedented time can also equip students to develop as compassionate practitioners.

While many students with good support and mentoring can gain effective clinical and communication skills in specialised end-of-life care settings, many students have and will be undertaking placements in which they will be expected to care for patients and their families at the end of life. Nursing degree programmes could consider end-of-life simulation that enable students to engage in role play exercises and that can be an effective and powerful pedagogical approach to death education.

Strengths and limitations

This study employed a purposive sampling to recruit participants that had experienced caring for a dying patient while on clinical placement as part of the undergraduate nursing programme. This non-probability sampling restricts a generalisation of the study and of those experiences of nursing students at other universities where diversity on the content of lectures or courses on end-of-life care may well

differ from this own sample. However, this approach to sampling was consistent in meeting the aims of this study to explore and gain insight into nursing student's experience of care of dying patients and managing the dead body. Moreover, since this study was undertaken during the COVID-19 pandemic and when social distancing measures were in place, it was able to capture the unique and specific challenges of student nurses' experiences during this time.

Conclusions

Responses by students in this study reveal the emotional challenges, as well as the privilege of providing end-of-life care. Developing as compassionate practitioners requires preparedness, and, in some instances, prior experience of death, dying and handling the dead body. Students' more negative experiences were attributed to a lack of mentorship, or open discussion of the emotional challenges involved in providing such care.

Good role models and education that helps students to prepare for this role are critical to enabling students to adopt coping mechanisms, as well as to forge relationships with patients and their families. Having the opportunity to discuss death and dying events with good role models can mitigate feelings of hopelessness. Indeed, a sense of achievement can be found among students who felt equipped to provide good quality care at the end of life, helping both patients and families. Through experience some students also developed a 'thicker skin', yet were able to grow to become compassionate practitioners. Therefore, educators on nursing programmes and managers supporting nurses could consider these findings and establish classroom, as well as continuing professional development simulation of the myriad experiences of caring for end stage patients. *IJPN*

Statement of interest: none

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CPD reflective questions

- Other than education and training, how can undergraduate nurses be better prepared to care for patients at the end of life and in post death care?
- To what extent can mentoring and supervision mitigate the impact of working in end-of-life care and performing post death care?
- How important is relationship building with patient's families in enabling student nurses to provide support and care?

Key points

- Formal education, such as simulation of end-of-life care settings, can enable nursing students to develop the confidence, skills and knowledge, to provide quality care at the end of life
- The provision of good quality mentoring support by trained nursing staff is essential to enable nursing students to provide compassionate care and support in end-of-life care
- Prior experience of death and dying either personally or in a clinical environment can enhance preparedness to perform care after death duties
- Good role modelling and supportive staff structures can help nursing students to adopt coping mechanisms to enable them to mediate the psychological and emotional impact of providing end-of-life care

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