Care of the Dying, Dead, and Bereaved: Developing the Curriculum Framework in Undergraduate Nursing Education

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Abstract

There is a lack of research in undergraduate nursing in end of life support and death in the Indonesian context. End of life care is less emphasised both in the pre-clinical and clinical training stages within the Indonesian curriculum compared to western countries. This study aims to develop an empirical and theory-driven curriculum framework for undergraduate nursing students in Indonesia focused on the care of the dying, dead, and bereaved.

This descriptive qualitatively-driven multimethods study is underpinned by a pragmatist paradigm that comprised of four sequential research stages. Stage one involved a scoping review of regional nursing curricula. Stage two involved in-depth semi-structured interviews with 13 nursing students and 17 nurse educators. Stage three included faculty curriculum mapping and a focus group discussion with eight key practitioners in the field of healthcare services and nursing education. All datasets were inductively analysed to identify similarities and differences, reflected in common themes and patterns. Finally, stage four developed the curriculum framework using findings from the previous stages, triangulated with recent publications.

The findings revealed international studies on end of life care education (EoLCE) predominantly focus on the exploration of perceptions, experiences, and effectiveness of such education. However, there is lack of clarity on how such curriculums and educational training are developed for undergraduate nursing students. Constraints emerged related to the curriculum and pedagogical practice to deliver care of the dying, dead, and bereaved, with a lack of curriculum alignment, limited pedagogy and teaching practice, unsupportive learning environment, and unprepared teaching staff. Exploring an evidence-based platform to design the curriculum based on situations and contexts is necessary. Further conceptualisation process revealed four core elements: enabling competency and meaningful learning outcomes, negotiated pedagogy and teaching practice, professional relationships, and supportive and facilitative environment. Findings thus elaborate the social cultural and transformative learning approach to baseline the curriculum development, focused on the care of the dying, dead, and bereaved for undergraduate nursing education, tailored to the Indonesian context.

Within the infancy of empirical studies about end of life care education in developing countries, this study offers a new opportunity to explore such issues in Indonesia. The research has identified barriers and drivers affecting the design and delivery of end of life care education in the Indonesia context. This study constructs a conceptual curriculum framework for undergraduate nursing students in Indonesia, based on the results of this study and relevant educational theory. The study reinforces the importance of using research to develop an integral, culturally appropriate, evidence-

based, and theory-driven curriculum for nursing students. Future research should focus on the development and evaluation of a curriculum and instructional design.

Keywords: care of the dying, dead, bereaved, curriculum development, end of life care, palliative care, nursing education, student nurses

Scholarly outputs from the study

Conference presentations

1. Agustina, H.R., Cox, K., Moffatt, C.J. and Johnston, B (2018) Undergraduate nursing students' experiences when caring for the dying, dead and bereaved in clinical learning environment. 6th Padjadjaran International Nursing Conference, Bandung, Indonesia. 24th to 26th May 2018. Bandung. Indonesia.
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Conference posters

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Abbreviations

AINEC	Association of Indonesian Ners Education Consortium
ASEAN	Association of South-East Asian Nations
CBE	Competency-Based Education
CDDB	Care of the dying, dead, and bereaved
CPR	Cardio-pulmonic resuscitation
DDB	Dying, dead, and bereaved
EoL	End of life
EoLC	End of life care
EoLCE	End of life care education
FGD	Focus group discussion
FoN	Faculty of Nursing
INA	Indonesian Nurses Association
INQF	Indonesian National Qualification Framework
IWG	International Working Group
LO	Learning outcomes
OBE	Outcome-based education
PC	Palliative care
PEOLC	Palliative and end of life care
PEoLCE	Palliative and end of life care education
QoC	Quality of care
QNF	Qualification of National Framework
WHO	World Health Organization

1 Introduction

1.1 Introduction

This chapter presents the background information for this study. It situates this study within an international context of the emergence and development of undergraduate end of life care education worldwide and then focuses on the Indonesian context. It discusses relevant aspects of Indonesia historical and cultural background, explains the structure and development of the healthcare system and considers nursing education in Indonesia.

1.2 Background

The World Health Organisation (WHO) has estimated that about 80 million people will die worldwide because of terminal illness, which account for the majority of deaths in resource-limited settings (WHO, 2013). Globally, dying in a hospital is the norm, with over half of all deaths now occurring in acute care hospital settings (Grubb and Arthur, 2016; Johnson, 2010). Of the patients who die in the acute hospital, 65% will die on inpatient units, emergency units (ER) or Intensive Care Units (ICU). Sadly, most of these patients die without receiving the appropriate end of life care (EoLC) (WPCA, 2014). Based on statistical information provided by WHO (2017), the occurences of cancer deaths throughout Asia accounts for 51.% of such types of death worldwides. The mortality of cancer patients is further estimated rising from 4.6 million in 2015 to 6.9 million by 2030, influenced by the rapid ageing of society (WHO, 2013). Such situation has contributed to increase the burdens of cancer in Asia (Takenouchi, 2018).

Nurses and other healthcare professionals frequently experience patients dying in healthcare settings. Nurses are the healthcare professionals who spend the most time with patients, often with 24-hour care at the bedside, directly interacting with patients and their families and coordinating care delivery with other healthcare team members. The relationship between healthcare professionals and patients and their families plays a significant role in ensuring the effectiveness of care and patient satisfaction. This requires particular skill and sensitivity when the patient is reaching the end of life (EoL). Regardless of care setting or stage of illness, nurses have a role in ensuring quality outcomes at the EoL for example, giving comfort care, providing sufficient information about health care status, offering emotional support for the dying and their family (Johnson, 2009). Therefore, nurses should have the right knowledge, skills, and attitudes to deliver practical, high-quality EoLC.

EoLC is a type of attention given to people expected to die within years, months or days. There is some ambiguity over the definition of EoLC, particularly in developed countries such as the US and UK (DHS, 2008; IOM, 2010; NHS, 2015). EoLC is considered a complex and demanding intervention, which involves addressing multidimensional needs including physical, psychological, social, economic, cultural, and spiritual needs (Ferrell et al., 2010; NICE, 2015). Furthermore, dealing with dying and death can provoke distress among health professionals, students, patients and their families (Bailey et al., 2014; Edo-Gual et al., 2014; Peters et al., 2013). Nurses and students often suffer from the adverse impact of dealing with dying, death and bereavement (DDB). Experiencing traumatic events with inadequate knowledge and skills may lead nurses and students to demonstrate unsupportive attitudes and avoidance behaviours towards dying patients and their families (Allchin, 2006; Costello, 2006; Ek et al., 2014; Muhto et al., 2010). Most nurses and students do not receive enough support either from peers or from organisations (Allchin, 2006). Unsupportive environments may further inhibit the development of compassionate healthcare professionals in the future (Edo-Gual et al., 2015).

International studies have highlighted that the majority of healthcare professionals are not well prepared to deal with dying and death during their undergraduate training (Costello, 2006; Ferrell et al., 2007). Literature reviews further found lack of educational content related to DDB in medical and nursing curricula across countries (Dickinson et al., 2008; Ferrell et al., 2005; Hirakawa et al., 2009; Wilson et al., 2011; Powar et al., 2015). Pre-established curriculum developed by End of Life Care Nursing Education Consortium (ELNEC), European Association of Palliative Care (EAPC), and Palliative Care Curriculum for Undergraduate Health Professional Students (PCC4U) have been proposed to support the improvement of end of life care education (EoLCE) for nurses and undergraduate nursing students (Cavaye et al., 2014; Gillan et al., 2013). There is a proliferation of studies reporting the effectiveness of using such curriculum among practitioners and students (Gallagher et al., 2014; Wallace et al., 2011; Lippe et al., 2015; Mallory, 2003; Takenouchi et al., 2013). Such studies were mostly conducted in resource-rich countries (Cavaye et al., 2014), and there are limited studies in resource-limited countries (Bassah et al., 2015; 2016, 2018; van der Wrath et al., 2015). In responding to current trends and issues in the health care delivery system in Asian countries, as highlighted above, efforts to increase nurses' awareness about their roles in practising EoLC that maintains patient dignity should be undertaken (Takenouchi et al., 2011). Therefore, developing a framework and network to disseminate EoLC nursing education is necessary.

1.3 The global context

1.3.1 Evolving end of life care

As with birth, death is a universal human experience which is inseparable from human culture and spirituality (Coolen, 2012; D'Antonio, 2017; Gao et al., 2012; Pulchaski et al., 2011). Cultural ideals include dying at home, surrounded by family and loved ones, although this traditional vision has changed since the 19th century due to the utilisation of advanced healthcare solutions to extend life and provide more sophisticated care, with the result that more people have tended to die in hospital while receiving life-prolonging treatment (D'Antonio, 2017).

Historically, the 1960s saw a change in attitudes towards and awareness of the importance of caring for the dying within Western healthcare settings (Cavaye et al., 2014; Wass, 2004). An initial study conducted by Glasser and Strauss (1967) indicated that health professionals show a lack of attention towards dying patients. In her seminal work, Quint (1967) evaluated US nursing school curricula and found that many of these did not adequately prepare students to care for dying patients. Similarly, the lack of attention among healthcare practitioners towards the suffering of dying patients triggered a British physician, Dame Cicely Saunders, to introduce the concept of 'hospice care' (Kings College, 2015), which was a conscious rejection of the predominant biomedical orientation of EoLC, especially its death denial culture (Saunders, 1969, cited in Kings College, 2015). Hospice care subsequently became a growing trend, popularised by the Kaiser Permanente in the US, which focuses on caring for people at the end of life (Institute of Medicine [IOM], 2010).

The utilisation of time and stage of illness as primary indicators of the end of life stage has been criticised since the 1980s (Izumi and Nagae, 2012). Lack of clarity regarding what constitutes the end of life may be related to the complexity and uncertainties of illness prognosis (Gysels et al., 2013). Real-life clinical situations make the transition from the acute or critical phase to the terminal phase challenging to identify (Australian Cancer Care, 2011; Gysels et al., 2013). Defining 'end of life' involves ethical considerations, which vary between institutional, professional, and cultural perspectives. Such variations result in many different interpretations of the end of life. Thus, there is no clear-cut definition of the end of life (Gysels et al., 2013).

Several sources have differentiated between the definition and scope of practice of palliative care and end of life care (PEoLC). The utilisation of 'palliative care' is often interchangeable with 'end of life care' in the context of education and practice (Goh et al., 2013; Cavaye et al., 2014; Just et al., 2013). In the US, the National Council for Palliative Care (NCPC, 2006) defines end of life care as that which 'helps all those

with an advanced, progressive, incurable illness to live as well as possible until they die' (p. 4). End of life care is often used interchangeably with various terms, including terminal, hospice, supportive, and palliative care (Gysels et al., 2013; Izumi and Nagae, 2012). Regardless of the terminology used, end of life care is undoubtedly a global concern. Within this type of care, health professionals must endeavour to identify the needs of service users for supportive and palliative care during the last phases of life and in bereavement. This may involve inclusion and facilitation of the performance of rituals or rites, and the ancillary provision of cultural and spiritual support for relatives during end of life care. This is alongside the discussion of health and safety issues and legal aspects relating to patients, families, and healthcare practitioners (Jevon, 2010; NHS, 2015; Pattison, 2007).

Healthcare professionals require sufficient resources and facilities to provide end of life care, including formal and informal education and training. Such efforts can help hospital managers to develop standards and practices that influence the process and outcomes of healthcare services. The exploration of end of life care in different contexts of healthcare systems can help healthcare practitioners to illuminate essential components and ways in which to deliver this care. Given that defining end of life care is itself challenging, it may be that the operationalisation of this concept in relation to structures, processes and outputs of practice, education and research, is more challenging still. This is particularly the case in developing countries, such as Indonesia, in which the ‘what’, ‘how’, ‘when’ and ‘by whom’ of EoLC in healthcare settings remains to be understood (Gysels et al., 2013).

In Indonesia, ‘palliative care' is considered to be synonymous with EoLC and is associated with providing spiritual care to dying patients (Agustina et al., 2017; Enggune et al., 2013; Rochmawati et al., 2017). This perspective may result in nurses focusing only on patients' spiritual needs, and tending to ignore their physical or psychological needs. There is also the possibility of providing inappropriate or overlapping care for dying patients and their families. For example, the nurse may delegate a part of their role to the family of the patient, such as maintaining personal hygiene and feeding the dying patient in the hospital ward. As a result, the promotion of holistic care at the end of life may not be fully achieved (Putranto et al., 2017). There needs to be an effort to clarify definitions and roles among healthcare practitioners, as a prerequisite for practice improvement. The term ‘hospice care' is interpreted as the provision of EoLC for the patient in community settings (Rachel House Foundation, 2015; Tedjawinata et al., 2012), and is not recognised in acute care settings in Indonesia. Hence, the term ‘hospice care’ is defined in relation to institutions, rather than formally stated at the national policy level.

Whilst it is difficult to separate such similar and interrelated concepts, there are differences in the needs of patients and families within different care contexts. Hence, regardless of the various possible definitions adopted, this study adopts the common term 'care of the dying, dead, and bereaved' (CDDB), rather than 'EoLC', using this to refer to the care given in the last days of life or when death is approaching, the moment of death, and after death (Smith-Stoner, 2011). Within this type of care, there may also be some consideration of supportive care or palliative care delivery as part of an end of life care package. For example, symptom management, such as the administration of analgesics, and holistic considerations of nutrition and hydration. Essentially, caring for patients and families experiencing death, dying and bereavement is considered the critical concern of end of life care, reflecting the context and culture of Indonesia and embedded within existing roles in nursing practice. Given the need for further exploration of what constitutes the end of life within different contexts and cultures in order to tailor appropriate end of life care options and solutions, research such as that carried out in this study is urgently required, particularly in resource-limited countries.

1.3.2 Challenges in end of life care education

International studies reveal the inadequacies in knowledge, skills and training of nurses and nursing students in caring for dying patients and their families (Allchin, 2006; Costello, 2006; Gallagher et al., 2014; Mallory, 2003; Muhto et al., 2010; Strang et al., 2014). Although the UK government has endorsed the End of Life Care Strategy (DHS, 2008), few standards relating to death education are found in the pre-registration nursing curriculum. In the UK, all pre-registration nursing programmes are required to comply with practice competencies identified by the Nursing and Midwifery Council (NMC), but only three out of 34 competencies relate to palliative care, and only one out of 10 standards relate to end of life care (NMC, 2010; Cavaye et al., 2014). As part of professional competency improvement, the revised NMC Code (NMC, 2015) includes five priorities of care for dying people. The Leadership Alliance for the Care of Dying People (LACDP) published 'One Chance to Get it Right' (2014), which sets out an approach to care of the dying in England, based on the needs and wishes of the person and those close to them, as well as 'Priorities of Care for the Dying Person: Duties and Responsibilities of Health and Care Staff' (2014). The priorities for the dying person focus on the recognition of the dying state, sensitive communication, involvement in decision-making, the needs of family caregivers, and individualised care plans. However, other countries, such as Germany and Argentina (Muhto et al., 2010), do not consider death education to be a mandatory element in their undergraduate pre-registration nursing curricula. No

studies could be found that identified dying and death education in the pre-registration nursing curriculum in developing countries.

There have been prolific efforts to evaluate and improve the EoLC curriculum approach following the global palliative care and hospice care movement in resource-rich/developed countries, mainly reflecting Western perspectives (CANLP, 2105; EAPC, 2010; ELNEC, 2015). In Asia, some studies explored the impact of using pre-established content from Western curriculums, modified according to local cultures and contexts (Jo et al., 2015; Takenouchi et al., 2013). Such curriculums may help faculty members to develop learning guides; however, using pre-established curriculums may not reflect the context and local situations that influence the provision of end life care. Hence, reviewing the curriculum that was implemented and evaluated to improve knowledge, skills, and attitudes is advantageous for nursing education institutions in resource-limited settings. This effort is needed to improve the educational processes and health system outcomes expediently.

Quint (1967, cited in Mallory, 2003) pointed out that a systematic death education with planned assignments should be given for undergraduate and pre-registration nursing students to improve knowledge and develop positive attitudes, as well as to help them feel less apprehensive when caring for dying patients. In the context of undergraduate nursing education, the development of the current EoLC curriculum framework based on theory and evidence is an urgent step to begin the dissemination of evidence-based practice (EBP) in EoLC in Indonesian nursing. However, since the majority of nursing curriculums used in developing countries tend to replicate the Western framework, the recognition of local and contextual factors should be taken into consideration when developing a national and local curriculum (Jayasekara, 2006; Kern et al., 2009; Ornstein et al., 2018; UNESCO, 2012; Uys et al., 2005).

Some studies have tentatively described Indonesian nurses' experiences and needs regarding EoLC in practice and clinical settings. They were found to demonstrate low levels of positive attitudes towards caring for the dying and their families in adult inpatient units (Fauziah et al., 2012). Nurses' educational background, previous training related to EoLC, working units (e.g. ICU and Emergency Department), and persistent contact with patients who are terminally ill or at the end of life were significant predictors of experiences and attitudes toward caring for the dying (Praptiwi and Covnel, 2014). Another study suggested that nurses need to improve their skills to recognise the signs and symptoms of dying, understand ethical dilemmas in decision making, and have standard operating procedures in EoLC

(Enggune et al., 2015), pain management, interdisciplinary communication, and professional development (Agustina et al., 2015).

International studies revealed that the vast majority of nursing education does not provide adequate content relating to dying, death and bereavement (Cavaye et al., 2014; Gillan et al., 2011). Although nurse educators have advocated dying and death issues as being essential, such topics still compete with other biomedical teaching topics (basic sciences, illness and pathophysiology, etc.) (Dickinson et al., 2008). Such a positivist worldview cannot acknowledge the complexity of EoLC, which covers the multidimensional needs of dying people and their families. Fragmentation of care can also result from disease-oriented care rather than patient-centred care (Mazzotta, 2013). Such a situation tends to make nursing education focused on managing diseases rather than providing holistic care. Hence, mechanical and technical care appears to have become the ultimate goal of nursing education. Within this situation, dying and death have continued to grow as ‘a hidden curriculum' (Condon et al., 2014). Since this is not their primary teaching agenda, nurse educators, are not obliged to extend their knowledge and skills relating to issues of dying and death.

End of life care is becoming increasingly crucial in Indonesia as more people are dying in hospitals rather than at home under the care of their families. However, the biomedical paradigm remains firmly entrenched in all aspects of professional healthcare, with no mandatory inclusion of psychosocial, cultural, and spiritual care in healthcare management (Putranto et al., 2017). Healing and recovery are thus identified with the biomedical results of active and aggressive treatment, rather than long-term patient outcomes, satisfaction, and wellbeing. In addition to failing to meet patients' needs, this increases workloads for health practitioners and results in inefficient resource distribution. Nurses are responsible for meeting the basic needs of dying patients and their families during hospitalisation, but, in the absence of policy and guidelines, little is known about how they provide end of life care in healthcare settings. Thus, the provision of EoLC has not been prioritised in most hospitals in Indonesia, and the majority of nurses are unprepared to care for the dying and their families. Further exploration of the services provided by nurses (often on an individual, ad hoc basis), and how education has prepared them when caring for the dying, dead, and bereaved, is intrinsically worthwhile.

1.4 The Indonesian context

1.4.1 Facts and figures

The Indonesian Archipelago in Southeast Asia comprises over 13,000 islands. Indonesia is categorised as a lower-middle-income country, with a population of approximately 257.5 million (World Bank, 2012). It contains over 300 ethnic groups with many cultural and religious groups. Native Indonesians include the Javanese (42%), Sundanese (31%), Melayu (3.7%), Madurese (3.3%), and numerous others (20%), mainly comprising indigenous peoples. There are five official religions: Islam (88%), Christianity (10%), and Hinduism, Buddhism, and Confucianism (2%). As part of the Pacific Rings of Fire, the islands were mainly formed by volcanic activity, and Indonesia has many active volcanoes and frequent earthquakes and tsunamis, in addition to floods and landslides precipitated by seasonal tropical storms. Such disasters often create massive deaths, physical injuries, psychological disturbances, and other health and social problems. The diverse geographical situations contribute to different standards and needs (relative to developed or Western countries) in the implementation of healthcare practice and education. Furthermore, high population density in urban areas creates a challenge to maintain a reasonable ratio between patients and health practitioners in acute care settings.

Figure 1 Map of Indonesia and Java Island

Source: Encyclopaedia Britannica (2019)

1.4.2 Health statistics and health care delivery system

WHO (2015) reported there is a changing pattern of diseases experienced by people in Indonesia in the last decade. Indonesia has the highest mortality rate caused by non-communicable conditions (680/100,000 living population) followed by infectious diseases (162/100,000) and injuries (49/100,000). The highest mortality rate is caused by stroke followed by cardiovascular illness, cancers and diabetes mellitus, tuberculosis and HIV/AIDS (Minister of Health, 2015). The inherent diversity and changing composition of Indonesian society challenge the provision of healthcare services to respond to the needs of increasing health problems caused by lifestyles, demographic patterns, and disease epidemiology. Nevertheless, since 2014, life expectancy has increased from 67 to 72 years among Indonesian females, and 65 to 69 for males, while the probability of dying aged 15-60 years is 205 per 1,000 for males, and 146 per 1,000 for females (WHO, 2015, 2016). With people living longer, more people are dying with chronic and degenerative diseases.

Table 1 Morbidity and mortality rate in Indonesia within the period 2016

Rank	*Cause of death*	*% of total death*	*No. deaths (thousands)*
1	Stroke	21.2%	328.5
2	Ischemic heart disease	8.9%	138.4
3	Diabetes	6.5%	100.4
4	Lower respiratory infections	5.2%	81.1
5	Tuberculosis	4.3%	66.7
6	Cirrhosis	3.2%	48.9
7	Chronic obstructive pulmonary disease	3.1%	48.1
8	Road injury	2.9%	44.6
9	Hypertensive heart disease	2.7%	42.2
10	Kidney diseases	2.6%	41

Source: Ministry of Health of Republic of Indonesia (2016)

Among the total population in Indonesia, approximately 29% are aged less than 15 years and 8% are senior. The majority of people live in urban areas (World Atlas, 2017). Given the large numbers of young and (increasingly) older people requiring care, health practitioners, especially nurses, are challenged to provide a wide range of EoLC, regardless of age and type of illness. The top ten causes of death can be seen in Table 1.

There are two categories of healthcare delivery systema in Indonesia: 1) public (or state), where all public hospitals and *Puskesmas (*primary health clinics) are funded

by government; 2) private, where private hospitals and clinics are run by private companies and individual organisations (Heywood and Harahap, 2009). The Ministry of Health (MoH) has centralised the integration and management of healthcare in Indonesia so that most healthcare is publicly provided and financed by the MoH (WHO, 2015). At the sub-district level, *Puskesmas* have been the cornerstone of essential health services and primary care since the 1970s, while district-level hospitals are the leading providers of curative care (Dewi et al., 2014). Referrals of complex cases are made to the higher-level hospitals (MoH, 2014).

Similar to other developing countries, healthcare access is limited for people living in Indonesia. Public healthcare services cost about 3% of the gross domestic product (GDP). Indonesia has 2,454 hospitals, of which only 882 are publicly owned, providing services to 275.5 million residents. In terms of health practitioners, less than one physician and 1.2 nurses or midwives are available for every 1,000 inhabitants (Heywood et al., 2009; World Atlas, 2017), while the recommended ratio is 8 out of 1,000 inhabitants (WHO, 2010). The low proportion of nurses to patients may affect the quality of care provision in general. Furthermore, the nurse workforce is concentrated in hospitals.This leaves fewer nurses available to provide home care services for vulnerable populations such as patients coming to the end of life.

In early 2014, the Indonesian government launched a universal health coverage (UHC), which covers most healthcare costs of citizens using both public and state healthcare providers, called *Jamkesnas or BPJS (*Department of Health, 2014). Within this policy, more people with significant health complaints prefer to go to hospital because that is where the majority of healthcare is provided and because it is now offered for free. This has led to a significant increase in hospital admissions and bed occupancy rates. This situation has increased the workloads among nurses and other health practitioners. Nevertheless, BPJS does not cover specific medical appliances and healthcare services, for example, specific chemotherapy agents, painkillers and home care services for cancer patients (personal communication with Suardi, 2015). Such a situation makes pain management less prioritised, and many discharged patients do not have follow-up care at home (Suardi, 2015). Hence, a terminally ill cancer patient may suffer from unmet needs and the family may not have adequate support during the caregiving period (Effendy et al., 2015; Kristanti et al., 2017). Some efforts have been made by Masyarakat Palliative Care Indonesia (MPI) or the Indonesia Palliative Society to persuade the government to include extra coverage for such services (Suardi, 2015). Accordingly, EoLC is an exclusive and hidden service, as it is not priorities in current healthcare settings in Indonesia.

1.4.3 Nursing education system

The Indonesian government has a national nursing curriculum for undergraduate nursing. The undergraduate nursing profile includes care provider, communicator, manager, educator, and researcher. These profiles guide curriculum developers to design relevant content for the undergraduate nursing programme level (DGHE, 2011; AINEC, 2012). Such recommendations have further assisted educational institutions in developing a competency-based curriculum (CBE) for undergraduate nursing education since 2007 (HPEQ, 2011; AINEC, 2012). CBE was initially created using an integrated learning model to facilitate the acquisition of students' knowledge, attitudes, and skills dealing with recent health problems. Despite some criticism for its lack of in-depth learning and fragmentation of knowledge and skills in clinical situations, CBE has stimulated critical thinking and independent learning capacity among students (Uys et al., 2007; Lenburg et al., 2011).

Indonesian undergraduate nursing education involves a five-year study plan, which consists of a core curriculum (144 credits in eight semesters) for the academic phase, and an internship programme (36 credits in two semesters). The delivered courses are mainly theoretical, with some nursing skills in laboratory practice. Palliative care theory is not included in the prescribed nursing texts, but it is introduced as a part of the Fundamentals of Nursing subject in one faculty (Syllabuses of FoN1, 2015). Students start their clinical placement, which includes shadowing clinical experiences (CCSA) during their third year and continue until the last year of their study (FoN Unpad, 2015). Upon completion of the fourth year, students are required to complete a one-year comprehensive internship programme that includes clinical and community settings, rotating through different specialities in various hospitals and other healthcare institutions. Throughout this year, nursing supervisors and preceptors in each unit evaluate nursing intern students. If the student achieves an unsatisfactory performance, they will repeat the clinical rotation until they have achieved the required outcomes.

After the completion of five years of training, nursing student graduates should undertake the national exit exam to qualify them as nationally registered nurses (AINEC, 2015). Regarding professional nursing development, the Ministry of Health has recently endorsed the Career Ladder System that consists of four levels: PK I (newly enrolled diploma nurse), PK II (experienced diploma nurses), PK III (registered nurses/specialist), and PK IV (nurse consultant) (MoH, 2017). This career ladder system can be used as a strategy to maintain nurse retention (Sandehang and Hariyati, 2017). However, there are wide disparities identified in current Indonesian higher nursing institutions between structure and agency, which further

leads to inequality and injustice of received educational opportunities (Effendi et al., 2018). Failure to identify the differences in competency level of academics, vocational, and professionals in the nursing area might lead to less accountability owned by education providers (HPEQ, 2014; Effendi et al., 2018). Curriculum reformation offers a chance to transform nursing in Indonesia.

1.4.4 Palliative and end of life care in Asia and Indonesia

According to global standards, the provision of end of life care is undertaken in a supportive matrix including the palliative and healthcare environment, human resources, affordability of care, quality of care and community engagement (Lien Foundation, 2015). Such components define the quality of death index, as reported by the Economist Intelligence Unit (EIU), which ranks Indonesia 53 out of 80 countries worldwide. This low position reflects less attention being given towards EoLC, including the lack of supportive policies and the absence of hospices to provide health services specifically for dying patients. In contrast, the UK achieved the first rank in 2015, which reflects excellent attention paid to palliative care in both the public and non-profit sectors (Lien Foundation, 2015). With a strong hospice movement, the government has integrated hospice care within the healthcare systems and included palliative care and end of life care (PEoLC) in national healthcare strategy (DHS, 2008). Also, new policies support the promotion of compassionate end of life care, which ideally supports enabling dying patients to die at home (DHS, 2008; NHS, 2015). With increased potential for dying and death in hospitals and other long-term institutions in Indonesia, the improvement of the end of life care quality is imperative. Nurses are therefore required to improve their knowledge and practice to provide high-quality CDDB.

No literature could be found that reported Indonesian students' experiences when dealing with dying and death during their academic or clinical practice learning experiences. Only one study measured attitudes towards the care of dying patients and their families among undergraduate nursing students in Indonesia (A'la et al., 2018). These study findings indicate the need to develop a more structured and systematic CDDB curriculum for the undergraduate level in Indonesia. Such situations warrant further exploration to illuminate the actual process of teaching and learning and to identify the recent gaps in the whole curriculum implementation. The need to develop the EoLC curriculum is in line with the government plans and policy mandates to improve professional competencies in nursing. AINEC (2015) revised the national nursing curriculum and added palliative care and EoLC as a compulsory subject in undergraduate nursing education (AINEC, 2016). However, the resultant curriculum, which prescribed general guidance on learning outcomes, content and

assessment methods, focused on palliative care within specific diseases, with limited content related to CDDB.

Until 2016 the Indonesian undergraduate nursing curriculum only allocated dying and death topics in the first (i.e. foundational) year of study (AINEC, 2012), and EoLC has not become a mandatory topic learnt during the academic and clinical learning stage. To have adequate learning experiences, studies suggested that the provision of EoLCE should start from undergraduate nursing education and then be followed by continuing professional education (Allchin, 2006; Mallory, 2003; Jeffers, 2014). There is a lack of studies describing the situation among students and faculty nurses. Further exploration of their voices is fundamental to formulate a CDDB curriculum with learning goals and interventions to increase competency in cognitive and affective learning and positive care outcomes in nursing students. Developing the CDDB curriculum appears a necessity within the current nursing agenda.

1.5 Problem statement and significance of study

There is a lack of evidence about the conditions of Indonesian nursing education and the opinions and experiences of nursing students and nurse educators about EoLC and CDDB.

Within the diverse cultures and religious backgrounds of Indonesian patients, nurses are challenged to understand each patients' unique values and practices. They might not recognise patient needs or place themselves at risk in attempting to provide irrelevant acts or inappropriate interventions for dying patients. Dealing with diverse societies requires a great understanding of the importance of cultural and spiritual aspects, which may influence the perception of the dying patients and their families towards their healthcare needs and their responses toward the care they receive. Health professionals are therefore expected to have competencies related to cross-cultural and spiritually sensitive care (Cavaye and Watts, 2010; Lippe et al., 2015). Given this situation, the promotion of a holistic care approach is particularly apt when caring for people at the end of life as part of interventions to improve the quality of dying and death.

Because dying, death, and bereavement are viewed as traditional and non-professional aspects of life among Indonesian people, there has been a tendency to exclude such important issues from current healthcare management. Therefore, EoLC has not become formally stated and prioritised in healthcare settings (Putranto, 2017). This problem may continue if health professionals are not aware of end of life issues, and they are also unprepared to care for dying patients and their families. This situation could be further aggravated by the absence of a formal CDDB

curriculum in health professional education sectors. Thus, it is necessary to conduct research to understand the EoLC needs of Indonesian nursing education to improve the quality of care provided in healthcare settings.

This study will make a significant contribution at the national and international level. At the national level, the CDDB curriculum framework informed by this study could be adopted as a prototype for a national policy to drive the development of professional nursing competencies and EBP. The findings of this study will contribute to the Ministry of National Education and the Association of Nursing Education in Indonesia in formulating EoLCE that complies with higher educational philosophies. The findings will also provide a guiding principle for undergraduate nursing institutions in Indonesia and will be beneficial to higher educational institutions offering undergraduate nursing programmes. It is expected to help administrators and academics identify the areas of the curriculum, instructional strategies, and organisational aspects that need to be reconsidered or improved. before they make a final decision about their curriculum.

1.6 Research aim and questions

This study aims to develop an empirically, and theory-driven curriculum framework focused on CDDB in undergraduate nursing programmes in Indonesia. Therefore, my study poses the following research questions:

1. What is known about CDDB in current undergraduate nursing education in resource-limited settings?
2. What are the perceptions, experiences, needs, barriers, and facilitators of CDDB in the learning environment?
3. What barriers and facilitators are perceived by nurse educators in clinical teaching and learning about CDDB?
4. What are stakeholders' opinions about curriculum component about CDDB for undergraduate nursing students?
5. How can the curriculum be developed based on the findings of this study?

1.7 The position of the researcher

I qualified as a registered nurse in 2001 after completing my BSN in Nursing Science at the University of Padjadjaran, Indonesia. Throughout my study, I undertook a Master of Nursing programme at Monash University in Melbourne, Australia. During my research, I choose palliative care as a final study project. For this purpose, I spent a month of fieldwork activities in a community-based hospice in one of the suburban

areas in Victoria. During my fieldwork, I observed several palliative nurses and physicians caring for people with palliative and terminal illness, either in hospice or in home care settings. Since then, I have been interested in studying and researching about palliative and EoLC development in nursing.

In 2007, I was in charge as the head of fundamentals of nursing department and a course coordinator of nursing foundation subjects at the Faculty of Nursing Universitas Padjadjaran. Within this role, I began to introduce the concept of palliative and EoLC into my courses. I attempted to officially disseminate the idea, which is considered a new topic for undergraduate nursing students. Such activities continued to develop when I was appointed as Vice-Dean of Students and Collaboration Affairs of the FoN Unpad from August 2009 until September 2014. Subsequently, I began a political journey and escalated the difficult campaign for embedding CDDB in nursing practice and education.

Throughout my career, a significant proportion of my workload was related to planning and designing a course within the classroom and blended learning format, managing student and collaboration programmes, supervising students in the clinical setting, and acting as a research supervisor for undergraduate and postgraduate students. I was also involved in the development of a palliative care task force in a collaboration between the faculty and teaching hospital. Within this scheme, I managed a capacity building programme for nurse practitioners and nurse educators by inviting experts in palliative care from a partnership with Non-Government Organisations (NGOs), and domestic and foreign universities. I also actively coordinated the dissemination of research in PEoLC both in national and local scientific forums. Such experiences strengthened my motivation to undertake doctoral studies in the UK.

In December 2014, I started my doctoral study, funded by an Indonesian government scholarship. I decided to research EoLCE, which is a fundamental aspect of care that should be learned by undergraduate nursing students. My decision was triggered by my own experiences when caring for dying and dead patients and the bereaved during clinical learning practice, particularly very challenging situations when facing such scenarios as a novice student. Unfortunately, there was no specific education in the Indonesian nursing curriculum at the time, nor operational definitions or frames of reference for such care.

1.8 Terminologies in this study

1.8.1 End of life care (EoLC)

Caring attention delivered in the last days of life, when death is approaching, the moment of death, and after death events (Smith-Stoner, 2011; Watts, 2013).

1.8.2 Care of the dying, dead and bereaved (CDDB)

To assist patients and their families facing imminent death to have the best quality of life possible until the end of their lives; to assist in handling care of deceased bodies; and to provide support for bereaved families, regardless of their psychosocial and cultural background (ICN, 1997; AACN, 2008; Izumi and Nagae, 2012; Watts, 2013; AINEC, 2015).

1.8.3 Curriculum

Curriculum is a set of educational plans to engage students in the obtaining of knowledge and skills leading to a degree or certificate. It also refers to the purposes, organisation, course delivery and its associated activities, and to the evaluation programme developed by an institution.

1.8.4 Curriculum development

Curriculum development involves the process of planning and designing the curriculum by which teaching and learning is conducted (Uys and Gwele, 2005).

1.8.5 Framework

The Cambridge Dictionary (2008) defines a 'framework' as "a system of rules, ideas, or beliefs that are used to plan or decide something".

1.8.6 Curriculum framework

UNESCO (2012) further defines the curriculum framework as 'sets the parameters, directions, and standards for curriculum policy and practice' (p. 6).

1.8.7 Curriculum mapping

Consideration of *when*, *how*, and *what* is taught, as well as the assessment measures utilised to explain the achievement of expected student learning outcomes (Harden, 2001).

1.8.8 Negotiated curriculum

Curriculum as a method and product resulting from negotiation and collaboration with relevant stakeholders and users.

1.8.9 Competence

Having the ability to perform sets of skills that are assigned according to professional roles and responsibilities (NHS, 2015).

1.8.10 Competency

A cluster of related knowledge, skills and attitudes that affect a significant part of an individual role or responsibility, which correlates with professional performance, and which can be measured against well-accepted standards, and improved via training and development (Gamondi et al., 2013, p. 89).

1.8.11 Learning outcomes

Learning outcomes mean the specific statements of what students are expected to know, understand and/or be able to do from a course or a class or activity.

1.8.12 Meaningful learning outcomes

Meaningful learning outcomes as the result of meaning making and critical reflection to baseline learning objectives, teaching and learning delivery.

1.8.13 Pedagogy

Pedagogy refers to teaching strategies including teaching planning and designing, and a style of teaching.

1.9 Thesis organisation

This thesis comprises a total of nine chapters. This chapter (Chapter 1) offers background information on the study contexts, discusses the significance of the research and the research aims and questions. The operational definitions of key terms used in the study are further presented.

Chapter 2 discusses the theoretical and conceptual framework within which the study is framed. This chapter begins with an overview of EoLC, and elaborates upon EoLC within the context of higher education and nursing education. Existing EoLC frameworks and research on EoLC are also described and discussed. The chapter then identifies the gaps in EoLC research in international, national and regional settings.

Chapter 3 identifies the methodology applied in the study. The section offers a brief overview of qualitative research methods, and then explains the rationale for selecting the pragmatic philosophy that underpins this research, and the qualitative exploratory mixed-methods approach used. Various types of data collection

procedures employed in the study are presented, and ethical issues associated with the study are addressed. This is followed by a section describing the study settings and the respondents who participated in this work.

Chapters 4, 5, and 6 detail the empirical findings resulting from each stage of the qualitative data analysis. Stage 1 presents a scoping review of Asian nursing curricula; stage 2 focuses on exploring students' and nurse educators' views about their experiences, perceptions and needs relating to CDDB; stage 3 describes a curriculum review and experts' opinions regarding suggested curriculum content; finally, stage 4 presents the development of a curriculum framework based on the findings of the study.

Chapter 7 presents a discussion of the findings of the study. The findings of the qualitative data analysis from stages 1, 2 and 3 are converged to answer the research questions.

Chapter 8 explores the process of reflexivity in relation to the data analysis, personal transformation, and lessons learned from the study.

Finally, chapter 9 discusses the strengths, limitations, and contributions of this study, and makes recommendations for future research.

1.10 Chapter summary

Within Chapter 1, I have introduced the overarching research questions and aim of this study. I have also presented information on the provision of EoLC in nursing practice and education services in Indonesia and explained how I have raised awareness about lack of training and insufficient curriculum focused on the EoLC in West Java. I have highlighted how the thesis is organised from chapters 1 to 9. In the next chapter, I present a critical review of the literature at the EoLC practice and education for nursing.

2 Literature Review

2.1 Introduction

The following scoping review presents the evidence relating to training provision in the care of the dying, dead and bereaved (CDDB), encompassing worldwide clinical nursing practice, undergraduate nursing programmes and ongoing professional development in the nursing field.

2.2 Methods

The planning phase of this review involved consultation with nurse practitioners, students and faculty members who had experienced difficulties in addressing dying and death-related issues and providing EoLC during their practice and learning. These observations informed an initial scan of the literature, which revealed that few studies had described curriculum design, integration of learning, or impacts on outcomes of education and training. Thus, a decision was made to undertake a scoping review rather than a systematic review (Brown, 2016).

Arksey and O'Malley's scoping review methodology (Arksey and O'Malley, 2005) was adopted in order to capture the breadth of existing knowledge on training in CDDB. A five-stage scoping review framework was adopted to guide the process, as follows: 1) identifying the research questions; 2) identifying relevant studies; 3) study selection; 4) charting the data; and 5) collating, summarising and reporting the results.

The research question was identified as follows: 'What is known already about care of the dying, dead and bereaved in current practice and education in nursing?'

The literature search was carried out using the electronic databases CINAHL, PsyInfo, MEDLINE (OVID), EMBASE, ERIC, and ASSIA. In addition, proQuest journals, proQuest thesis and dissertation and EThos (University of Nottingham database systems) were searched, along with grey literature (via Google and Google Scholar). The search terms used are shown in Table 2.

Table 2 Literature search terms

No.	Terms used
1	Terminal care/ **OR** palliative care/ **OR** dying and death **OR** end-of-life care.mp.

2	Knowledge **OR** attitude **OR** skills **OR** competence
3	Attitude to death **OR** perception.mp. **OR** experiences.mp
4	Nursing education **OR** undergraduate teaching
5	Nursing student **OR** undergraduate student
6	Nurses **OR** practitioner nurse*
7	Faculty **OR** teaching staff **OR** nurse educator **OR** clinical instructor **OR** preceptor **OR** mentor
8	Curriculum development **OR** curriculum design **OR** course development **OR** course design
9	Guidelines **OR** standards **OR** policy **OR** recommendation
10	2 **OR** 3
11	4 **OR** 5
12	6 **OR** 7
13	8 **OR** 9
14	10 **AND** 11 **AND** 12 **AND** 13
15	1 **AND** 14
16	Asia **OR** Indonesia
17	15 **AND** 16
18	Limits '17' with January 1990 – December 2015, English

During the screening phase the title, abstract and full text of each article were assessed against the inclusion criteria. Eligible studies included quantitative, qualitative or mixed methods studies which explored undergraduate or pre-registration students and the experiences and perspectives of their nursing mentors and faculty staff on education in CDDB, either in the classroom or clinical learning environment (hospital or community). Studies which considered the process of course or curriculum development and curriculum implementation for healthcare and nursing education were also included. Excluded studies were those unrelated to practice, education or training in the area of dying, death and bereavement. Papers that were not written in English and did not have translation available, or for which the full text could not be retrieved, were also excluded.

Whilst a scoping review does not specifically aim to assess the quality of studies (Arskey and O'Malley, 2005), quality assessment tools from the Joanna Briggs Institute of Evidence-Based Health Care (JBI) were used to assess the included studies. JBI-MASTARI was used for assessing the quality of quantitative studies and JBI-QARI was used for assessing the quality of qualitative studies (Jayasekara, 2008; JBI, 2014). In addition, JBI-NOTARI was used to assess text and other

narrative opinion (JBI, 2014). For more details, see the scoring sheet produced to aid the appraisal process presented in Appendix K.

Publications were searched that related to empirical research, curriculum design and published guidelines. All publication types (e.g., research studies, commentaries, evaluation reports, book chapters, curriculum descriptions) were eligible for inclusion. Information from the selected articles was recorded, including the setting, study design, results, and any recommendations made (Brown, 2016). A data extraction form was developed to include descriptive information and thematic categories (see table 5). Furthermore, data were thematically analysed following Levac et al. (2010) and Brown (2016), with descriptive codes generated to illustrate the themes and categories that emerged from the literature. These codes were then synthesized further into overarching categories and themes.

2.3 Results and discussion

The search of electronic databases yielded 903 titles and abstracts. Grey literature and reference list searches yielded a further 62 records (n=52 and n=10 respectively), making the total record 965.

After duplicates were removed (n=825), 325 titles and abstracts were assessed against the inclusion and exclusion criteria, and a resulting 120 full texts were retrieved and screened. Of these, 50 papers were excluded as they did not report the experiences and needs of students or nurse educators. Of the remaining 70 records, 48 were research articles and 22 were grey literature. Thirty articles were from the US, Latin America and Canada, 18 from the UK and EU, 6 from Sub-Saharan Africa, and 16 from Asia-Pacific. The PRISMA flowchart is shown in Figure 2.

The majority of studies used qualitative research designs with phenomenological approaches and descriptive exploratory study. Only three studies involved nurse educators (Bratjman et al., 2011; Bandeira et al., 2013; Jeffers, 2014). The majority of studies involved undergraduate nursing students or practitioner nurses. Only one identified both students and nurse educators (Brien et al., 2008).

Of the quantitative studies, most used self-report instruments to assess knowledge and attitudes towards dying and death (Mallory, 2003; Muhto et al., 2010; Iranmanesh et al., 2010; Chow et al., 2013). The one mixed methods study (Chow et al., 2013) used only a small sample size, thus limiting the power of its conclusions.

Following the thematic analysis, five categories were identified from the included studies. These were: 1) attributes and scopes of practice of care of the dying, dead

and bereaved, 2) psychological and social impacts of dying and death exposures among students and nurses, 3) factors influencing practice of care of the dying, dead and bereaved, 4) content and pedagogical approach, and 5) theoretical models and frameworks in the curriculum.

A thematic summary of the included studies is presented in table 3 below, and the evidence from the literature on each of these themes is presented in the Discussion (see section 2.4).

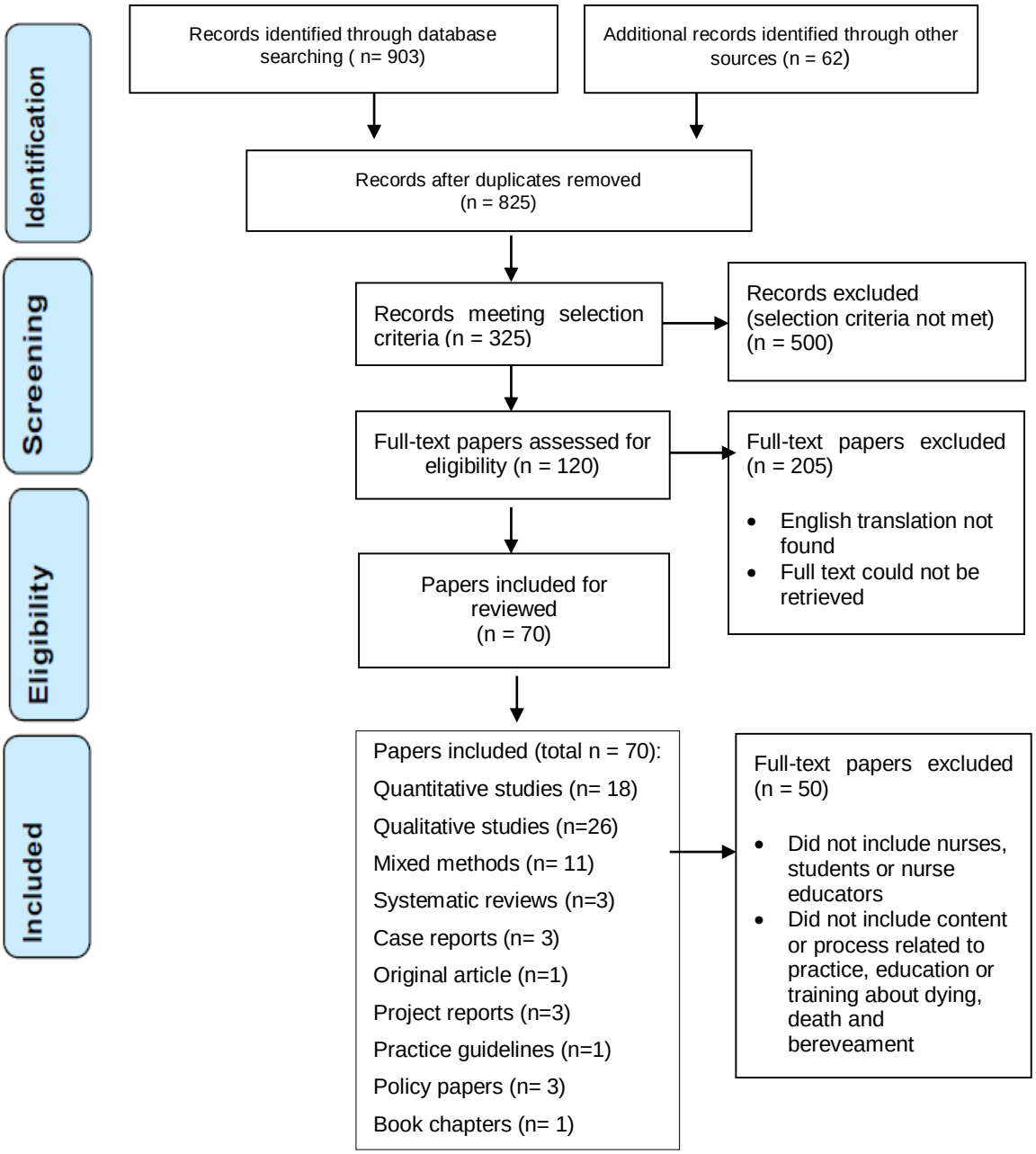

Figure 2 PRISMA flow chart of the searched articles

Table 3 Thematic summary of included studies

No	Study and country	Aims of study	Methodology and methods	Main findings	Themes
1	Mallory (2003), US	To evaluate the effectiveness of structured end of life care education	Quasi-experimental, Frommelt-Attitudes Toward Care of the Dying scale, statistical analysis, 3rd year of undergraduate nursing students	Mezirow's Transformative learning theory and Quint's theory underpinned teaching and learning sessions. Teaching module comprising 45 hours, over 15 weeks, of classroom-based teaching using theory and role play.	Theoretical and models of the framework in curriculum
2	Von Rooyen et al. (2005), South Africa	To explore the experience of students during the accompaniment of the dying patient and after death care and to develop guidelines for clinical mentors/staff wards about the accompaniment programme	Descriptive phenomenology used unstructured interviews with 59 students. Data were analysed using Tesch's methods.	Guidelines developed focusing on intrapersonal relationships, the involvement of ward staff in the accompaniment of students, and encouraging transcendental relationships.	Psychosocial Impacts of dying and death. Factors influencing the practice of care of the dying, dead and bereaved
3	Allchin (2006), US	To explore the experiences of students when facing dying and death in clinical practice	Hermeneutic phenomenology used semi-structured interviews with 20 students. Data were thematically analysed using Colaizzi's method.	Emergent themes: 1) Initial hesitancy and discomfort; 2) reflective musing; 3) personal and professional benefits.	
4	Niedderiter (2009), US	To explore students' experiences and roles when providing care to dying patients	Qualitative phenomenology used in-depth interviews with 13 junior nursing students.	Essential components of nursing education include an emphasis on the domains of thoughts, feelings, communication, multicultural diversity, education, and coping mechanisms.	
5	Mutto et al. (2010), Argentina	to develop undergraduate nursing students' experience and attitude toward dying patients; and training in end-of-life issues.	Descriptive semi-structured survey with multicentre study involved 680 students from eight universities. Data were analysed using the ANOVA test.	Emergent themes from the semi-structured survey: 1) Wish to prepare to offer better care and benefit for terminally-ill patients, 2) wish to avoid affective involvement and painful personal experiences for nurses, 3) wish for personal enrichment and opportunities for personal growth.	Attributes and scope of practice Psychosocial Impacts of dying and death
6	Adesina et al. (2014), Australia	To explore a cohort of third-year undergraduate students' attitudes, experiences, knowledge, and education concerning end-of-life care.	A mixed-methods survey used an open-ended and self-reported instrument. Data were analysed using thematic analysis.	Themes generated: 1) Importance of students' values and beliefs; 2) influence of experiences; 3) views about 'good or bad' death; 4) knowledge about ethics and legislation.	Factors influencing the practice of care of the dying, dead and bereaved

7	Watts (2014), UK	To explore nursing undergraduates' understandings of palliative care	Descriptive qualitative study used in-depth interviews with 11 final-year nursing students. Data were analysed using thematic content analysis.	Participants' awareness of the broad scope of palliative care and valuing of compassionate care and emotional supports. Inconsistencies in students' differentiation between palliative and end-of-life care. Students focus on the imminent dying phase.	Psychosocial Impacts of dying and death
8	Parry (2011), UK	To explore nursing students' experiences of their first death in clinical practice, to help identify educational, training, and support needs	Phenomenology study with a focus group of five students	Themes identified: 1) Emotional influence (shock/fear; the speed of deterioration of the patient; symptoms observed; own perceptions vs. reality; needs to cry); 2) role of mentor (relationships with a mentor; culture of a mentor; support from a mentor); 3) relationships (including with patient, link to own family, support mechanisms, relationships with patient's family; dignity); 4) skills (what to say; lack of perceived preparation; last offices).	Attributes and scopes of practice
9	Edo-Gual et al. (2014, Spain	To explore nursing student's experiences of death and dying in clinical practice	Interpretive phenomenology used semi-structured interviews with 12 nursing students. Hermeneutic data analysis with Colaizzi's method.	Emergent themes: 1) Impact; 2) training in EoLC; 3) moral issues; 4) coping; 5) learning/growth/healing connections.	Psychosocial Impacts of dying and death
10	Ek et al. (2013), Sweden	To describe first-year nursing students' experiences of witnessing death and providing end-of-life care	Descriptive phenomenology used interviews with 17 nursing students. Data were analysed using Van Manen's method.	Emergent themes: 1) Thoughts of the death being more frightening than the actual experience; 2) daring to approach dying patients and offering something of oneself; experiences of 'not sufficing' in the face of death; 4) being confronted with one's own feelings.	
11	Gallagher et al. (2014), Australia	to describe nursing students' experiences of death and dying while on clinical placements and in their personal lives	Mixed methods study used survey and individual interviews with 17 nursing students	Palliative care education alone did not totally eliminate negative feelings. Dedicated role-models, well-developed education resources, supportive learning environment and emotional supports all enhance students' ability to provide EoLC.	
12	Bailey et al. (2014), UK	To evaluate the impact of an educational workshop on undergraduate nursing students' attitudes to caring for end-of-life patients	Mixed methods used pre-post questionnaires (FATCOD) and free-text response involved 122 students. Data were analysed using the statistical package and thematic analysis.	Significant increase in attitudes scores amongst respondents. Students who had received previous education on death and dying tended to report greater benefits from the workshop delivered.	Content and pedagogical approach

13	Johnston et al. (2006), UK	To explore the perceptions of patients and nurses of palliative care and the concept of the expert palliative nurse	Phenomenology used in-depth interviews with 22 hospice patients and 22 nurses followed by Colaizzi's method of data analysis and Benner's theory for the interpretation of findings.	Palliative care nurses experienced both effective and ineffective interpersonal communication, the building of therapeutic relationships with dying patients, and attempting to control patients' pain and distressing symptoms. Patients and nurses agreed that expert palliative nurses show interpersonal skills and qualities such as kindness, warmth, compassion, and genuineness.	Attributes and scope of practice
14	Ellman et al. (2012), US	To develop, create and implement blended learning programme for teaching cultural and spiritual aspects of palliative care	Sequential mixed methods used free-text responses and open-ended questionnaires that involved 217 students. Data was analysed using quantitative and content analysis.	Medical students showed poorer scores in several areas than other students. Blended learning promoted students' meaningful engagement with learning materials and programmes.	Factors influencing CDDB
15	Bloomfield et al. (2015), UK	To design, implement and evaluate simulated based learning for enhancing communication with dying patients and their families	Mixed methods study used focus group discussion, trials, and pre-post survey to measure outcomes of intervention. Participants were medical and nursing students.	Both medical and nursing students lacked confidence in communicating with dying people and their relatives. Simulation learning increased self-perceived confidence levels in communicating with patients and families.	Curriculum and pedagogical approach
16	Wilson et al. (2011), Canada	To evaluate death and dying education in undergraduate nursing programmes	A descriptive email survey was used to collect data from 29 nursing schools/faculties across Canada. Data were analysed using a statistical package.	Death education was reported more often in the past as being integrated throughout the curriculum, despite nursing schools/faculties having shifted to PBL methods.	Curriculum and pedagogical approach
17	Hold et al. (2015), US	to evaluate palliative and end-of-life education as a nursing elective subject	Qualitative study used self-reported instruments with 19 students	Themes identified: 1) Learning from stories; 2) learning from being there; 3) learning from caring. Students' understandings about EoLC were enhanced by incorporating teaching strategies addressing the apprenticeships.	
18	Wallace et al. (2011), US	To provide a current state of end of life care education in a university	A mixed-methods study used a survey with 111 students. Data were analysed using a statistical package.	Integration of curriculum has the potential to improve students' knowledge about PC and to enhance EoL nursing care.	
19	Lippe et al. (2015), US	To compare perceived competence and attitudes in caring for dying patients with students performing the	Pretest-posttest design used Palliative Care Competencies (PC-ELNEC), and the Concerns About Dying Scale 128 students were recruited from three different cohorts.	Following a simulation exercise, cohorts showed significantly improved scores on perceived competence and attitude measures.	

20	Arbour et al. (2014), US	To understand the experiences of critical care nurses when caring for patients and their families during the transition from aggressive life-saving care to palliative and end of life care	Descriptive phenomenology study used in-depth interviews with 19 ICU nurses. Data were inductively analysed using Colaizzi's method.	Developed categories: Educating the family; advocating for the patient; encouraging and supporting family presence; managing symptoms; protecting families and creating positive memories and family support. Teaching and mentoring novice clinicians are highly important.	Attributes and scope of practice Psychosocial Impacts of dying and death
21	Engler et al. (2004), US	To describe neonatal nurses' perceptions of bereavement/EoLC of families of critically or dying children	Descriptive cross-sectional used a mailed survey distributed to 240 hospitals in the U.S.	Nurses felt discomfort in providing culturally-sensitive bereavement and EoL care. Education on bereavement/EoLC and cultural competence is necessary.	Factors influencing CDDB
22	Costello (2006), UK	To investigate nurses' experience of death and dying in a hospital	Ethnography used in-depth interviews with 29 Registered Nurses. Data were interpreted using semiotic analysis.	Determinants of a 'good death' include control over death event, the high degree of predictability, established awareness, patient's death being desired by staff, and appropriate time of death. A 'bad death' refers to suddenness and unpreparedness, nurses' inability to prepare due to time/context constraints, death occurring out of normal ward confines, unawareness, insufficient time, lack of dignity and respect, uncertainty, traumatic death, experiences of (unrelieved) pain.	
23	Cook et al. (2012, UK	To describe and understand behaviour and coping strategies used by pediatric nurses for dying children in the acute cardiology unit	The qualitative descriptive study used semi-structured interviews with 11 expert nurses. Content analysis was applied to analyse data.	Emergent categories: Boundaries; memories; disconnecting; labeling. Colleague support, institutional resources, and nurses' experience levels are critical to the process of coping.	Psychosocial Impacts of dying and death
24	Kent et al. (2012), New Zealand	To explore the clinical circumstances, impact and challenges and rewards of nurses' early experiences with patient death.	A sequential mixed-methods study used online survey with 174 nurses. Data were analysed using a statistical package.	Nurses' first experiences of patient death occurred during undergraduate training (61%) or newly-qualified practice period (23%) in which death occurred in acute medical, surgical or specialty settings in public hospitals that involved paediatric or sudden unexpected deaths.	Psychosocial Impacts of dying and death
25	Gerow et al. (2010), US	To describe the lived experience of nurses surrounding the death of their patients	Qualitative phenomenology used semi-structured interviews with 11 registered nurses. Data were analysed using Heidegger's hermeneutical analysis and van Manen's method.	Four themes were identified: reciprocal relationship transcends professional relationship, initial patient death events are formative, nurses' coping responses incorporate spiritual worldviews and caring rituals, and remaining "professional" requires compartmentalizing of experience.	Psychosocial Impacts of dying and death

				Understanding nurses' grief and coping processes can provide better learning opportunities and a supportive working environment.	
26	Reinke et al. (2010), US	To identify nurses' perspectives on nursing skills that are important yet under-utilised in end-of-life care	A descriptive exploratory study used a 45-item survey that recruited 717 nurses in four states. Data were analysed using Chi-square and content analysis.	Under-utilised skills included communication skills, pain, and symptom management competencies, especially those concerning anxiety and depression, issues related to patient-centered care systems, an interdisciplinary approach.	Attributes and scope of practice Factors influencing CDDB
27	White et al. (2011), US	To assess EoLC core competencies deemed most important	Descriptive, cross-sections used mailed surveys. The ranking method is used to analyse data.	Symptom management is the most important core competency, followed by communication and palliative care philosophy. Both quantity and quality of EOL continuing education are inadequate. Educational gaps exist in EOL nursing care.	Psychosocial Impacts of dying and death Factors influencing CDDB
28	Brajtman et al. (2009), Canada	To examine the potential needs for faculty development in end-of-life care of theory and clinical educators	Descriptive exploratory used Palliative Care Quiz (PCQN) and FATCOD, and an adapted Educator Educational Needs Questionnaires. 53 respondents were recruited using purposive sampling. Data were analysed using content analysis and descriptive statistics.	Barriers related to teaching PC related to lack of formal integration of EoLC content in the current curriculum, overburdened, and lack of time. Personal education needs, preferred learning formats, supports, and barriers to teaching EoLC, time allocation, and sources of learning are thus necessary.	Psychosocial Impacts of dying and death Factors influencing CDDB
29	Jeffers (2014), US	To explore the experiences of clinical nurse instructors when they guide students who care for dying patients	Interpretive phenomenology used semi-structured interviews with 10 nurses. Data were thematically analysed using Colaizzi's method.	Understanding the experiences and perceptions of clinical nursing faculties when teaching EOLC to students contributes to the improvement of teaching and learning strategies. This in turn impacts on students' ability to care for the dying in their clinical practice.	Factors influencing CDDB
30	Todaro-Francheschi et al. (2014), US	To describe the current state of EoLCE in U.S nursing schools	The exploratory descriptive study used a survey distributed to nurse educators from 233 nursing institutions.	Emergent themes relating to barriers to the implementation of EOLC education: Faculty resistance; inadequate support from administration; lack of classroom time to devote to the subject. Nurse educators need to champion EoLCE in their nursing schools by following current issues in practice and society	Factors influencing CDDB

31	Johnson (2009; 2011), Australia	To understand the experience of students and new graduate nurses when caring for the dying patient and their family	Sequential explanatory mixed methods study used survey distributed to nursing schools and expert panels.	EoLC is viewed as a 'hidden curriculum' that can impede gaining formal knowledge and skills. A need exists to reform undergraduate nursing curricula to enhance graduates' preparedness for caring for the dying and their families.	Factors influencing CDDB Curriculum and pedagogical approach
32	Condon et al. (2014), US	To explore the notion of the hidden curriculum and how to surface EoL issues in practice and education	Reflective writing of three faculty members from the same institutions.	The necessity of exploring beliefs regarding EoLC among nurse educators to avoid the presentation of the hidden curriculum. Failure to recognise and respect such differences can lead to a hidden curriculum.	Factors influencing CDDB
33	Brien et al. (2008), Canada	To report the experience of students and nurse educators in the development of competency based EoLCE	A case report of pre-post of 4-week EoLC course implementation and evaluation used FATCOD and free-text response in an undergraduate programme	Components identified relating to capacities and skills in EoLC. The difficulty of evaluating the transfer of affective learning to observable interpersonal skills may impact actual practice. Need for further research to evaluate affective learning implementation.	Psychosocial Impacts of dying and death
34	Just et al. (2010), Germany	To identify learning goals and objectives for palliative care curriculum	The mixed-methods study followed Kern's Six-Step approach using systematic review and expert opinions.	Categories of learning goals identified from undergraduate curricula review, a systematic review, and expert rounds were geriatrics, palliative care, communication, and patient autonomy, organisation, and social networks. Domains of learning objectives used cognitive, affective, and psychomotor	Attributes and scope of practice Curriculum and pedagogical approach
35	Kavanaugh et al. (2009), US	To develop a blended learning model to deliver loss, grief, and bereavement for nursing students	A case report of the development of blended learning used pragmatism and Kolb's experiential learning.	Students can achieve successful learning through encouragement, active learning, respect for diverse talents and ways of learning, communication, prompt feedback, and time spent on the task.	Curriculum and pedagogical approach
36	Ramjan et al. (2010), Australia	To describe the integration of palliative care content into a three-year undergraduate nursing programme	The integration of palliative care content into the existing curriculum followed a spiral and iterative approach.	Recommendation for integrated palliative care education to be embedded in a four-year undergraduate nursing curriculum. The spiralling approach can be used to link and apply the content to a new area of learning and to consolidate palliative care learning experiences.	Curriculum and pedagogical approach

37	Loos et al. (2014), Australia	To explore students' reflection about the sudden death of a patient during clinical practice	Reflective writing	Students need to acknowledge, and thus accept, their grief as a way of reducing the chance of disenfranchised grief. Formal and informal support is needed to manage negative feelings relating to this.	Psychosocial Impacts of dying and death
38	Hegarty et al. (2010), Australia	To explore the inclusion of palliative care in undergraduate health services curricula and its barriers and opportunities	A scoping study used literature review and email surveys of deans of health faculties in Australia (n-62). Data were analysed using descriptive statistics.	The majority of curricula have included palliative care content from a minor to a moderate degree. There are variations in terms of teaching hours, teaching, and learning methods.	Curriculum and pedagogical approach
39	NICE (2011), UK	To provide a practical guideline when caring for adults in the last years of life	Quality standards based on expert consensus	Sixteen key standards developed: Identification, communication and information, assessment, care planning and review, psychological support, social support, spiritual and religious support, family and carers, coordinated care, urgent care, specialist palliative care, care in the last days of life, care of the dead body, death verification, bereavement support, training, and planning.	Attributes and scope of practice Curriculum and pedagogical approach
40	EAPC (2010), UK	To guide palliative care education in an undergraduate nursing programme in European countries	Project report of the development of palliative care education guidelines based on task force works.	Competency domains established: Understanding the concepts of palliative medicine and palliative care; organisational planning; partnerships; awareness of healthcare politics and educational system. Recommendation for the principle of adult learning and multiple methods of teaching delivery. NB. Outcomes measurement was not specifically mentioned.	Attributes and scope of practice Curriculum and pedagogical approach
41	Mok et al. (2002), Hongkong	To explore the experiences of students when caring for the dying patients by using PBL	The qualitative study used a reflective journal of 96 nursing students. Data were analysed using content analysis.	Emergent themes: 1) Increased self-awareness; 2) positive attitudes towards death; 3) providing culturally-sensitive care. Tutorials and PBL served as an effective teaching strategy for nursing educators in the area of death education.	Factors influencing CDDB practice Curriculum and pedagogical approach
42	Iranmanesh et al.(2010), Iran	To compare the attitudes of Iranian and Swedish nursing students toward caring for a dying person	The descriptive comparative study used an instrument (FATCOD) and the Death Attitude Profile Revised (DAP-R) with 223 students from Iran (n=110) and Sweden (n=113).	Educated groups showed more positive attitudes than non-educated groups towards care of the dying patient No significant difference in death attitude scores between the two groups. Little time devoted to dying and death in the curriculum.	Curriculum and pedagogical approach

43	Bloomer et al. (2013)	To describe the way nurses working in ICU care for family members through the patient's dying and death	A qualitative exploratory descriptive study utilised two focus groups of ICU nurses. Data were analysed using inductive content analysis.	Nurses reported inadequate training to address complex care needs of families during patients' dying phase and after death, which made them relied on peer-mentoring and role-modelling to improve their care.	Attributes and scope of practice Factors influencing CDDB practice
44	Connolly et al. (2014), UK	To develop a palliative care competence framework for health and social care professionals in different settings	Scoping review used key published documents and a series of expert meetings.	Six domains of core competencies identified: 1) principles of palliative care; 2) communication; 3) comfort and quality of care; 4) care planning and collaborative practice, 5) loss, grief, and bereavement, and 6) professional and ethical practice in the context of palliative care	Attributes and scope of practice
45	Smith-Stoner (2009; 2011), US	To develop a learning model for EoLCE	A case report of simulation base learning for undergraduate nursing students	Using the 'Silver Hour' based on PCC and 'ways of knowing' theory as a guide for teaching students to plan care through three phases (dying, death, and dead).	Curriculum and pedagogical approach
46	Poultney et al. (2015), UK	To report the implementation of end-of-life care education in a university	A case report of classroom-based learning for nursing students from six cohorts.	A 'perceptions of dying' session was developed using combined methods (lecture, small group discussion, film, and reflective practice), which focused on four themes: dealing with patients and family, practical issues, emotions, guilt, or blame. Sessions were delivered for pre-clinical and clinical learning students.	Curriculum and pedagogical approach
47	Murray et al. (2015), Canada	To explain the content of palliative and end of life care for undergraduate nursing education	Book chapter	Nine domains of competency related to EoLCE: Symptom management; relational skills; interprofessional collaboration; ethics; cross-cultural care; education; delegation.	Attributes and scope of practice
48	Taylor (2012), UK	To identify learning outcomes in EoLC for developing continuing education and training programme	Project report of task force conducted document reviews and series of workshops	EoLC learning outcomes developed based on four aspects of clinical/professional practice: Clinical/direct patient care; leadership and collaborative practice; improving quality and developing practice; developing self and others.	Attributes and scope of practice Curriculum and pedagogical approach
49	Park et al. (2014), Korea	to investigate students' experience of their first encounter with the death of a patient during clinical practice	Phenomenology used in-depth interviews with 11 students and data was analysed using Colaizzi's method.	Eight themes emerged: 1) Desire to evade the reality of death; 2) powerlessness; 3) changed emotion from the anticipation of recovery to fear of death; 4) various interpretations of death; 5) limitations of nursing practice; 6)	Psychosocial Impacts of dying and death

				longing for knowledge about death; 7) resentment of lack of nurses; 8) motivation for self-growth.	Factors influencing CDDB practice
50	Nwozichi et al. (2015), Nigeria	To interpret the lived experiences of nursing students when dealing with death and dead bodies	Hermeneutic phenomenology used reflective diaries of 12 students, which data were analysed using an interpretive approach	Emergent themes: 1) Personal reflection on harsh reality; 2) lack of availability of required support, abandonment; 3) identification of individual strengths and weaknesses based on experience	Psychosocial Impacts of dying and death
51	Shih et al. (2006), Taiwan	to ascertain the perceptions of nursing students about death and help expected from nurses during the dying process.	Exploratory qualitative study used open-ended, self-reported questionnaires that recruited 110 senior students. Data were analysed using thematic analysis.	Students' reported needs during the dying process were directed towards three main goals: 1) Help in reaching the 'triple targets of an individual life'; 2) help in facilitating in-depth support so that both the dying person and significant others can experience a blessed farewell; 3) help in reaching a destination in the afterlife.	Psychosocial Impacts of dying and death
52	Chow et al.(2013), Taiwan	To identify and compare nursing students' groups based on their demographics, clinical experience, knowledge, perceived competency, and attitudes towards end-of-life care.	A cross-sectional survey recruited 253 nursing students. Data were analysed using cluster analysis within a specific study cohort.	Differing amounts of clinical experience in EoLC for students in different clusters. Female students had greater empathy but showed less perceived competency.	Curriculum and pedagogical approach
53	Jo et al. (2015), Korea	To examine the effects of a humanistic end of life care course among undergraduate nursing students	Quasi-experimental used non-equivalent control group design pre-post-test design that recruited 39 students.	All variables except death anxiety demonstrated significant improvement. No difference in death anxiety scores between the two groups after completing the courses. A humanistic EoLC course was effective overall in minimising negative attitudes towards death and improving communication skills.	Curriculum and pedagogical approach
54	Van der Wrath et al. (2015), South Africa	To explore and describe nursing education experiences of EoLC using a constructivist learning model	The qualitative descriptive study used reflective writing that involved second-year students. Data were analysed using open coding.	Themes emerged relating to participants' sensory and emotional experiences during learning. Students reflected on what they had learned and clarified their values relating to death and dying. Constructivist model and experiential learning are recommended to develop EoLC competency among nursing students.	Psychosocial Impacts of dying and death Curriculum and pedagogical approach

55	Thacker (2008), US	To describe nurses' perceptions of advocacy behaviours in end-of-life care nursing practice in acute settings	The comparative descriptive study used Ethics Advocacy Instrument (EAI) that recruited 317 nurses from three regional hospitals	Novice nurses experienced less frequency compared to experienced and expert nurses regarding communication, relationship with patients, personal beliefs and compassion, and the family support the practice of advocacy in EoLC. Findings thus reveal the importance of identifying supports and barriers nurses towards advocacy practice at different skill levels experiences.	Factors influencing CDDB practice
56	Msiska et al. (2013), Malawi	To explore perception and experiences of students during clinical learning practice	Hermeneutic phenomenology used conversational interviews with 30 students (3rd and 4th year). Thematic data analysis used Colaizzi's method.	Students used emotional labour as a practice method to deal with anxieties when facing dying- and death-related events during clinical learning placement. Emotional support and clinical supervision helped to reduce students' emotional burdens.	Psychosocial Impacts of dying and death
57	Jawahar et al. (2013), India	To assess nursing students' perception of death and dying.	The descriptive study used semi-structured questionnaires distributed to 210 nursing students from different cohorts.	The majority of students showed distress when dealing with dying and death which was categorised into three aspects: thoughts, feelings, and challenges. Students need further evidence-based death education to teach about dying, cultural competence, communication skills, and coping with emotional stress.	Psychosocial Impacts of dying and death Factors influencing CDDB practice
58	Kongsuwan et al. (2009), Thailand	To explore the ways that nurses could promote peaceful death and to attempt a definition of a peaceful death	The descriptive exploratory study used telephone interviews with	Nurses can promote peaceful death by using a three-dimensional process: awareness of dying, creating caring environment dan promoting end-of-life.	Attributes and scope of practice
59	Chan et al. (2009), Singapore	To explore the factors associated with nurses' and midwives' attitudes towards perinatal bereavement care.	The descriptive correlational study used a questionnaire distributed to 185 nurses/midwives in a hospital. Data were analysed using a regression model.	Nurses/midwives with religious beliefs and those with more positive attitudes to the importance of hospital policy and training for bereavement care were significantly more likely to have a positive attitude towards bereavement care. Thus, bereavement counseling and preceptorships supervision are necessary.	Psychosocial Impacts of dying and death Factors influencing CDDB practice
60	Zheng et al. (2014), China	To elucidate Chinese oncology nurses' experience of caring for dying cancer patients.	The qualitative descriptive study used semi-structured interviews with 28 nurses who care for terminally ill patients. Data were thematically analysed.	Themes identified: 1) EoLC for dying cancer patients; 2) EoLC for family members; 3) cultural sensitivity and communication; 4) moral distress and self-limitations; 5) self-reflection and benefit-finding. Death is regarded as a taboo subject in traditional Chinese culture.	Factors influencing CDDB practice

61	Fonseca et al. (2012), US	To identify nursing intervention provided at the end of life	A systematic review of international literature.	Domains of nursing intervention in EoLC: 1) Capacity; 2) knowledge and skills of the caregiver; 3) accompaniment by a nurse; 4) involvement in care; 5) emotional support; 6) information and education; 7) spiritual support; 8) promotion of resting moments.	Attributes and scope of practice Factors influencing CDDB practice
62	Modeste (2015), South Africa	To develop competency-based education in HIV/AIDS for undergraduate nursing students	Mixed methods used to survey and Delphi method.	Three competency categories identified, covering seven core competencies: 1) Foundation (knowledge); 2) supporting pillars (ethics, policies, interdisciplinary approach, personal and professional development); 3) performance (health education, holistic safe practice).	Curriculum and pedagogical approach
63	Jayasekara (2008), Srilangka	To develop an evidence-based conceptual framework for undergraduate nursing curricula	Descriptive qualitative exploratory used systematic reviews and focus group discussions with nursing experts. Data were analysed using content analysis.	Major components of undergraduate nursing curriculum framework identified: Professional nursing, skills, beliefs and values, knowledge, and teaching and learning. Basic elements of curriculum framework were identified: scope of practice, pre-registration nursing education, teaching and learning, curricula content, EBP, recourses allocation and funding, and image of nursing.	Curriculum and pedagogical approach
64	APCA (2014), Africa	To inform academic and practitioners about palliative care core competencies	Policy papers	Domains identified: 1) Organisational development; 2) holistic care provision; 3) education and training; 4) research and management information.	Attributes and scope of practice
65	Cavaye et al. (2014), UK	To review dying and death education in pre-registration nursing programmes	Integrative review used literature from major databases from 2000 to 2013.	Inconsistencies identified in educational provision; variations in quantity, content, and approach. There remains a deficit in several key areas, including knowledge, skills, organisation of care, teamwork.	Factors influencing CDDB practice
66	Bassah et al. (2014), Cameroon	To examine educational approaches used in pre-registration palliative care nursing education, and to discuss implications of curriculum development in resource-poor countries	A modified systematic review of 17 studies used major databases from 2000 to 2013.	Pre-registration palliative care nursing education was developed using Kern's six-step approach and Kolb's experiential learning underpinned instructional designs. Several challenges might hinder effective PC education in resource-limited settings. These relate to resources, funding, facilities, and supports. Thus, innovative educational strategies are needed to bridge these barriers in practice and education.	Curriculum and pedagogical approach Factors influencing CDDB practice
67	Shadu et al. (2010), India	To determine palliative care awareness among undergraduate health care students	Non-randomized population-based study involved medical and nursing students.	Deficiencies in understanding palliative and end of life care philosophy, pain and symptom management, communication, and interdisciplinary care for patients and their families.	Factors influencing in CDDB practice

				Focused on teaching methods and institutional change strategies in facilitating reform.	Curriculum and pedagogical approach
68	Ferrell et al., (2015), US	To explain about the development of end-of-life care nursing education consortium project	Original article	ELNEC - Core curriculum has eight domains of practice, which are Introduction to palliative nursing; pain management; symptom management; ethical issues; cultural and spiritual considerations; communication; loss, grief, and bereavement; final hours.	Attributes and scope of practice
69	Stephen et al (2012), UK	To identify bereavement care education and training in Scotland	Multimethod study with a review of UK's literature, a survey questionnaire distributed to key contacts, and qualitative interviews with key participants. Datasets were analysed using content analysis.	Bereavement care appears lacking in across curriculum and training programmes for health professionals in the UK, which triggers the need for developing interprofessional education and training for bereavement care.	Attributes and scope of practice Factors influencing CDDB practice
70	Gamondi et al. (2013), UK	To address the issue of education and training for palliative care health professionals	White Paper	Three levels of palliative care education are palliative care approach, general palliative care, and specialist palliative care. Core constituents of PC are autonomy, dignity, relationship, quality of life, position towards life and death, communication, public education, multiprofessional approach, and grief and bereavement. Ten core competencies in palliative care include apply core constituents, enhance physical comfort, meet psychological needs, meet social needs, meet spiritual needs, response to family carers, clinical-ethical decision making, interdisciplinary teamwork, interpersonal and communication skills, and practice self-awareness and professional development.	Attributes and scope of practice

2.3.1 Attributes and scope for practice of care of the dying, dead and bereaved

Care of the dying, dead and bereaved encompasses various multidimensional aspects, including effective communication, expert care, and professional relationships. Attributes and scope for practice of CDDB as identified in the literature relate to students' knowledge, attitudes and skills, which further relate to the wider scope of practice in CDDB, including assessment and symptom management, communication and relationships, ethics and values, patient- and family-centred care, cultural and spiritual awareness, and after-death care provision.

2.3.1.1 Assessment and symptom management

It is clear that nurses often struggle to recognise patients who are dying because they have a lack of knowledge and skills in EoLC (Costello, 2006; Reinke et al., 2011). In a systematic review of studies of nursing care at the end of life, Fonseca et al. (2012) emphasised the importance of nurses' ability to provide capacity for EoLC needs (e.g. hygiene, nutrition, elimination, pressure areas, use of equipment, symptom control, drug administration). In addition to symptom management, patients at the end of life were also identified as requiring psychosocial care, including a sense of control, quality of life and well-being (Fonseca et al., 2012; NICE, 2015).

2.3.1.2 Communication and relationships

Professional relationships are important in meeting the needs of people receiving both EoLC (Mok et al., 2004; Johnston et al., 2006; NICE, 2014) and bereavement care (Engler et al., 2004). Intra- and inter-personal relationships play a significant role in establishing a positive caregiving process and enhancing the quality of dying and after-death care (Mok et al., 2004; Johnston et al., 2006; Smith-Stoner, 2011). Likewise, communication barriers, which may relate to differing beliefs, values and cultural perspectives between nurses and their patients and families, can hinder caregiving relationships. Students also experience difficulties in communicating with dying patients and their families (Allchin, 2006; Niederriter, 2009; Parry et al., 2011; Ek et al. 2014; Adesina et al., 2014). During the EoL phase, families of dying patients expect health practitioners to display excellent communication skills, compassionate behaviours, and attention to reducing their burdens (NICE, 2015). Nurses need to demonstrate a commitment to being present, developing meaningful relationships, building open and honest communication with clients, fostering trust and hope, and providing comfort (Mok et al., 2002; Engler et al., 2004; Johnston et al., 2006; Arbour et al., 2014).

2.3.1.3 Ethics and values

Lack of clinical experience and poor understanding of ethical and legal issues are considered major constraints when caring for patients at the end of life (Reinke et al., 2010; Kent et al., 2014). In a study by Shih et al. (2006), nurses reported difficulties with

decision-making in withdrawing or withholding life-supporting devices, resuscitation, and other interventions. Nursing students also experienced ethical and moral dilemmas when dealing with dying and death-related issues in clinical practice (Park et al., 2014; Adesina et al., 2014; Nwozichi et al., 2015). Having better understanding about ethical decision making and advocacy in EoLC practice is therefore necessary (Thacker, 2008; NMC, 2015). Providing education for nurses on good death, ethics and EoLC-related legislation and advocacy is therefore essential (Shih et al., 2006; Thacker, 2008; Adesina et al., 2014).

2.3.1.4 Patient and family centred care

NICE (2011) released practice guidelines on the care of adults in the last years of life, which emphasise the patient and family as a core unit in practice. Person-centred care (PCC) (Mead and Bowers, 2000) has also become an emerging pathway in delivering EoLC in Western contexts (NICE, 2015; NHS England, 2015). PCC previously underpinned the 'Silver Hour' model (Smith-Stoner, 2011) as a practice and learning approach to the care of the dying and dead. However, this PCC model does not accommodate several crucial issues which require attention, such as futile interventions, multicultural diversity, and the imminence of death. Nurses are expected to enable transition care from supportive and palliative towards end of life care (Bloomer et al., 2013). For this purpose, professionals and non-government organisations (NICE, 2015; NMC Code, 2015) further mention the importance of paying attention to the needs of the family caregivers of dying patients. No further studies were found regarding the application of a patient- and family-centred care approach in CCDB practice and education in the resource-poor settings.

2.3.1.5 Cultural and spiritual awareness

Cultural and spiritual dimensions play major roles in the provision of care at the end of life. Different cultural and religious backgrounds and beliefs may lead nurses to have different perspectives on dying and death from those of patients and their families (Nieddrieter, 2009). In one qualitiative study, Zheng et al. (2015) discovered that Chinese oncology nurses struggled with social taboos relating to death on the part of patients and families. Chan et al. (2009) found that nurses face difficulties in supporting bereaved parents of dying children in hospitals, which relate to families' reluctance to discuss death. This may lead to disengagement in the caregiving process, particularly when nurses have a lack of capacity to deal with stress and confict in EoLC (Engler et al., 2004).

Lack of spiritual awareness among health practitioners, lack of confidence in addressing religious issues, and a reluctance to refer to chaplains, may also hinder the fulfilment of patients' spiritual needs in healthcare settings. Thus, understanding how culture can influence the process and outcomes of EoLC and bereveavement care is important (Engler et al., 2004; Chan et al., 2009; Kongsuwan et al., 2009). Nurses need to be

aware of and improve their ability to assess patients' spiritual needs and help them and their families to make decisions that are consistent with their values and goals for EoLC (Engler et al., 2004; Gerow et al., 2010). Efforts are therefore required to improve nurses' and students' understanding of contextual factors in EoLC through comprehensive education and training.

2.3.1.6 After-death care provision

Few studies have reported the roles of nurses during the 'last offices' or in delivering care after death (Gerow et al., 2010). Nurses have a role in preparing the deceased for transfer to the mortuary. They are also required to maintain dignity and respect towards the dead body and the family of the deceased, and to aid in fulfilling any religious or cultural obligations or beliefs when providing care after death. However, nurses and students are not well prepared to provide care after death, in particular with aspects such as covering or shrouding the body or the head or face (Parry, 2011). Other studies have confirmed that students often experience emotional distress when seeing a dead body for the first time (Ek et al., 2014; Nwochizi, 2015), or when observing rapid decline in physical function and witnessing sudden death (Niedderiter, 2009; Kent et al., 2012). Therefore, ensuring students' and nurses' readiness to provide care after death for the first time is highly important (Smith-Stoner et al., 2011; Park et al., 2014). Particular attention needs to be paid to their learning needs and emotions (Brien et al., 2008; Gerow et al., 2010; Parry et al., 2011), the patient's family and caregivers (Smith-Stoner, 2011), and available practice guidelines (NICE, 2015). However, bereavement care appears to be lacking across the reviewed literature. Only one secondary study (Stephen et al., 2012) mentioned bereavement care training for healthcare professionals. The importance of adequate support and education about dying, death and bereavement for students and nurses was highlighted in the literature, in order that practitioners might advance their coping strategies for facing similar situations in the future.

2.3.2 Psychological and social impacts of dying and death exposures

A number of studies have identified barriers in the delivery of EoLC education. The factors identified have included psychosocial impacts and support and facilitation.

2.3.2.1 Social and emotional impacts

The first experience of dealing with death is a salient moment for nurses (Kent et al., 2012). In one phenomenological study, Allchin (2006) showed that most nursing students experienced 'reflective musing', in which their emotional reaction to death could not easily be removed from their memory, yet at the same time the care of the dying patient was experienced as being rewarding. In contrast, other studies have found that many students experience feelings of powerlessness and hopelessness when

facing dying and death in clinical practice (Parry, 2011; Ek et a;. al, 2014; Park et al., 2014).

Previous experiences may impact the way in which nurses and students go on to provide care for the dying on subsequent occasions. Muhto et al. (2010) discovered that students' responses differ as their learning advances. Whilst first year students expressed more willingness to care for dying patients, third year students more typically articulated a wish to avoid affective involvement with dying clients. In contrast, Ek et al. (2015) found first years students experienced more negative emotions than third year students when facing dying and death during clinical learning sessions. Overall, studies concluded that lack of emotional management training in EoLC curricula may contribute to students being emotionally unprepared for contact with dying patients.

Several studies have reported that nurses struggle to cope with loss, grief and bereavement during their clinical practice (Engler et al., 2004; White et al., 2011; Cook et al., 2012; Chan et al., 2009). Similarly, students find it challenging to deal with their feelings when caring for dying patients and their families (Allchin, 2006; Parry et al., 2011; Adesina et al., 2014; Ek et al., 2013) and when seeing a dead body (Park et al., 2011; Loos et al., 2014; Nwozichi et al., 2015). Students demonstrate physical stress-related symptoms when they cared for dying persons and their families such as nausea, muscle tension, and headache (Jawahar et al., 2013). Besides, studies reveal students and nurses often practice 'emotional labour' (Horschild, 2010 cited in Msiska et al., 2013) when facing dying and death. Such event can trigger further stress among nursing students and novice nurses undertaking clinical learning practice on hospital wards. Emotional labour is considered a coping mechanism used by students and nurses to deal with dying and death events (Msiska et al., 2013). Such labour requires nurses to hide their genuine emotions, which may contribute to feelings of emotional exhaustion and distress (Horschild, 2010).

Understanding one's own and others' emotions is important for nurses when dealing with dying, death and bereavement (Engler et al., 2004; Cook et al., 2012). It is thus essential for nurses to cultivate self-awareness during their practice (Smith-Stoner, 2011). Engaging in self-reflection may assist nurses in understanding their own motives, biases and expectations towards their roles and responsibilities. Guidelines and training may assist in this regard, for example, Bailey et al. (2014) suggested three stages of development to develop expertise in EoLC: investment of the self in the nurse-patient relationship, management of emotional labour, and development of emotional intelligence. Nurses' capacity in caring for people at the end of life may also be addressed via professional development programmes (Baker et al., 2013; Lippe et al., 2015) and by restructuring nurse training courses (Brajtman et al., 2009; Todaro-Franceschi et al., 2012).

2.3.2.2 Support and facilitation

Whilst nurse educators have been recognised as playing a significant and varied role in the teaching and learning process (Jeffers, 2014), few studies have discussed the specific involvement of nurse educators in the delivery of clinical placements for EoLCE. It is recognised that nurse educators play a role in assisting nursing students to understand and address their emotions and anxieties relating to dying and death (Allchin, 2006; Jeffers, 2014) and to face their own grief (Condon et al., 2014). At the same time, the past experiences (both personal and professional) of nurse educators in relation to death and dying may impact on students when this knowledge is transferred in the clinical setting (Brien et al., 2008; Bandeira et al., 2013; Chow et al., 2015). For example, some educators have reported apprehension when discussing dying and death-related issues with students (Brajtman et al., 2007; Bandeira et al., 2013). As Jeffers (2014) suggested, lack of training among teachers may result in their lacking capacity to guide students in clinical settings.

Students and nurses in several studies have confirmed a need for adequate clinical supervision and emotional support in order to minimise their psychological burden (Von Rooyen et al., 2004; Nwozichi et al., 2015; Engler et al., 2004; Gerow et al., 2010). Clinical support can reduce nurses' emotional fatigue and burnout when dealing with dying patients and death (Kent et al., 2014) and when working with bereaved families and caregivers (Shih et al., 2006; Gerow et al., 2010; Loos et al., 2014). Appropriate EoLC training can also help students in providing more personalised care, as well as reducing emotional burden and encouraging greater acceptance of death (Bailey et al., 2014; Edo-Gual et al., 2015).

2.3.3 Factors influencing practice of care of the dying, dead and bereaved

Multiple factors have been found to influence the ability of students and nurse educators to provide CDDB in the clinical environment. These include personal factors, such as perceptions, beliefs and values about dying and death, lack of knowledge, attitudes and skills in EoLC, limited clinical experiences, and lack of education and training. In addition, institutional factors have been shown to be important, including poor curriculum content and design, lack of support and facilitation, lack of clinical learning experiences, and socialisation and hidden curricula.

2.3.3.1 Perceptions, believes and values

Nurses' perceptions of 'good' versus 'bad' death play a role in influencing CDDB. Costello (2006) found that nurses perceived that a good death involves patient and family awareness, an appropriate time and place in which to die, and the experience of death as a relief. In contrast, a bad death related to nurses' inability to prepare good EoLC, and lack of communication between patient, family and healthcare providers – constraints which may contribute to lack of dignity in the dying process.

Personal beliefs and values are a further major factor identified as influencing CDDB. Death is not always viewed as an acceptable topic of conversation among patients, families and healthcare practitioners. Indeed, talking about death may bring about a feeling that the family has lost hope (Iranmanesh et al., 2009; Nieddrieter, 2009). There is also controversy about giving patients bad news about terminal illness. In western culture, the prevailing belief is that the patient has a right to know their diagnosis in order to make informed decisions about their care (Nieddrieter, 2009). Telling the truth, however, may conflict with the values of more 'collective' cultures (Hofstede, 2010), in which it is felt to be in the best interests of the patient not to 'burden' them or destroy their feelings of hope (Iranmanesh et al., 2009; Nieddrieter, 2009). A related issue concerning personal beliefs and values is that of the place of death. In China, nurses often found that families do not wish to have their dying family members die at home because this may bring bad luck (Zheng et al., 2015). In contrast, Muslims more often do prefer to die at home, surrounded by family members (Heidari et al., 2014).

From a teaching point of view, personal beliefs and attitudes about palliative care and EoLC have been shown to similarly influence the delivery of EoLCE. Condon et al. (2014) found that faculty members' own experiences influenced their beliefs towards palliative and end of life care. Todaro-Fransceschi et al. (2014) and Ferrell et al. (2015) discovered that faculties' reluctance to accommodate dying and death topics in the teaching syllabus, along with a lack of institutional support, was viewed as a major constraint influencing EoLCE. Condon et al. (2014) argued that faculty members must be aware of, and make allowances for, differing viewpoints within the curriculum. Therefore, in evaluating the curriculum, an assessment of palliative and end of life care beliefs and experiences among nurse educators is essential.

2.3.3.2 Knowledge, attitudes and skills

Regarding the role of nurses' knowledge and skills in EoLC, studies have shown that the majority of nurses have difficulty recognising the signs and symptoms of dying, managing symptoms in the last days or hours of life, communicating with patients and families about dying and death issues, and providing care after death (Engler et al., 2004; Costello, 2006; Cook et al., 2012). Students' fears of rejection from patients' family members, and feelings of inadequacy in answering questions from dying patients or their families about their prognosis, often challenge communication and lead to avoidance of difficult conversations (Parry et al., 2011; Ek et al., 2013; Adesina et al., 2014; Park et al., 2014). In the UK, Bloomfield et al. (2015) observed that problems communicating with dying patients could be minimised, and students' self-competence in breaking bad news enhanced, via further training and by adopting an interdisciplinary approach.

2.3.3.3 Socialisation learning

Literature reveals the 'hidden curriculum' reflects the 'lack of explicit curricular objectives around end of life care topics' that 'results in limited exposure to death and dying topics in pre-registration programmes' (Condon et al., 2015). The process of professional socialisation, entailing the acquisition of values, behaviours and attitudes necessary to assume a professional role (Johnson, 2009), has an impact on EoL nursing practice. Professional socialisation can be considered a 'hidden curriculum' which has a pervasive and powerful impact on students. In EoLCE, a hidden curriculum may well exist which values diagnostic and therapeutic skills, and in which a biomedical culture prevails (Johnson, 2009; Condon et al., 2014). The hidden curriculum tends to result in EoLCE not having a formal structure and thus creating intangible practice and learning (Johnson, 2009). This may lead to students experiencing difficulties and lacking knowledge and skills in areas which require humanistic talents, communication abilities, tolerance to diversity and attention to patient and family responses to illness. Therefore, professional development focusing on pedagogy practice, continuing education and in-service training programs are necessary to enable nurses and students to provide good EoLC.

2.3.3.4 Professional development

Nurses report needing more education to give them the skills to deliver sensitive news without undue stress (Coyle, 2011; Reinke et al., 2012), and to confidently support bereaved individuals (Engler et al., 2009; Fai et al., 2010). Students also need to know how to communicate with dying patients and their family (Niedderiter, 2009; Muhto et al., 2010), manage negative emotions and fear of the unknown (Edo-Gual el, 2014; Ek et al., 2013) care for the dead body (Parry et al., 2011; Nwozichi et al., 2015), and to provide grief and bereavement care (Gerow et al., 2010; Loos et al., 2014). EoLCE is needed to enable students to be aware of their feelings, responses and reactions to death (Allchin, 2006; Brien et al., 2009), and to deal with ethical and moral dilemmas (Adesina et al., 2014). Specific education about dying, death and bereavement has further been highlighted as reducing harms and promoting students' and nurses' emotional wellbeing. Therefore, developing structured education and training in DDB is required for both classroom and clinical practice.

2.3.3.5 Clinical experiences

Literature has highlighted that novice nurses often struggle when facing dying, death and bereavement during their initial clinical practice (Costello, 2006; Thacker, 2008; Reinke et al., 2013; Anderson et al., 2015). Having adequate knowledge, skills and clinical experiences in CDDB can reduce their personal distress and improve professional relationships with dying patients and their families (Mok et al., 2004; Johnston et al., 2006). Similarly, Chow et al. (2014) found that Taiwanese nursing students with more extensive clinical experience had more positive attitudes and higher

perceived self-competence than others. However, Gallagher et al. (2014) found that, in an Australian-based palliative care unit, feelings of powerlessness and hopelessness among final year undergraduate nursing students did not diminish after engaging in palliative care education. Lack of emphasis on emotional management and mental health issues in EoLC curricula may contribute to students being emotionally unprepared for contact with dying patients (Brien et al., 2009; Edo-Gual et al., 2014). Thus, there is a recommendation for active and experiential learning strategies for teaching about dying, death, and the dead, which are applicable to both practising clinicians and nursing students.

2.3.4 Content and pedagogical approach

Traditional approaches to education, which are teacher-led or instruction-based, may be less suitable in the context of dying and death education (Cavaye et al., 2014), since understanding death, dying and bereavement occurs through a process of learning and building relationships with others, which are in turn influenced by social, cultural, historical and contextual dimensions (van der Wrath et al., 2015). Findings from the scoping review identified three elements of the curriculum that involved supporting the importance of end of life care education: contextualisation of learning, authencity in teaching and clinical practice, and competency and outcomes.

2.3.4.1 Contextualisation of learning

Contextualisation of learning refers to linking educational content with meaningful situations that are relevant to students' lives in order to facilitate effective learning, which can ensure continual growth (Dewey, 1981 cited in Forester, 2013). Integration of EoLC into the undergraduate curriculum contributes to the improvement of knowledge, skills, and self-competence among nursing students (Ramjan et al., 2010; Wallace et al., 2011; Lippe et al., 2015). However, the integration of learning might challenge the measurement of learning outcomes (Lippe et al., 2015). Curriculum developers should therefore consider the timings of delivery of EoLC education components to students (Ramjan et al., 2010). They also need to consider how students receive, assimilate, and potentially transform their attitudes toward care of the dying (Mallory, 2003, p.311). The AACN (2015) asserts that EoLCE should begin at the first level of the nursing programme.

Findings indicate that a spiral curriculum approach (Bruner, 1960; Miller, 2010) is used as the framework of learning integration in health professional education and EoLCE (PCC4U, 2010; Ramjan et al., 2010; Wallace et al., 2011; Ellman et al., 2012; AACN, 2015; Murray et al., 2015). The spiral learning approach emphasises the simple-to-complex level of knowledge and skills acquisition among both students (Bruner, 1960 cited in Ramjan et al., 2010) and nurses (Benner, 1984 cited in Johnston et al., 2006; Lippe et al., 2015), which reflects the zone of proximal learning development (Vygostky,

1978 cited in van der Wrath et al., 2015). The spiral learning approach also has positive aspects such as flexibility to revisit content and stimulation of learning retention, and early preparation prior to clinical placements (PCC4U, 2010; AACN, 2015). However, curriculum developers should be mindful when delivering palliative care topics during the early years of study, since students at this stage have less prior knowledge and clinical experience (Mallory, 2003). Nevertheless, students may benefit from having early exposure to knowledge to prevent them from developing false ideas and assumptions about care of the dying based on clinical experiences (Mallory, 2003).

2.3.4.2 Authenticity in teaching and learning

Various types of teaching and learning approaches in EoLC have been reported that reflect contextulisation of learning as discussed in the previous section. Several authors suggest that death and dying education could be constructed following the principle of transformation learning (Mallory, 2003; Smith-Stoner, 2009; 2011; van der Wrath et al., 2015), with a combination of didactic teaching and active learning resulting in stronger learning retention than using a single method (Cavaye et al., 2014). Blended learning (Kavanaugh et al., 2009; Ellman et al., 2012), combining face-to-face, online and simulation-based learning, has been shown to offer a comprehensive and safe learning environment to teach about complex issues such as communication, ethics and decision-making, loss, grief and bereavement, and interdisciplinary teamwork (Bloomfield et al., 2015; Jo et al., 2015; Kavanaugh et al., 2009; Ellman et al., 2012). The importance of clinical experience has been emphasised, and lack of opportunity to care for dying patients in clinical rotations has been shown to hinder the process of achieving competence (Chow et al., 2014), particularly when palliative care units do not exist to support clinical learning experience (Edo-Gual et al., 2014).

Table 4 Summary of learning methods in dying, death and bereavement education

Design	Author
Didactic learning	Mallory (2003); Kavanaugh et al. (2009); Bailey et al. (2014)
Problem-based learning	Mok et al. (2002)
Small group discussion	Mok et al. (2002); Smith-Stoner, 2011; Jo et al. (2015)
Project-based learning	Jo et al. (2015)
Simulation-based learning	Smith-Stoner, 2011; Bloomfield et al. (2015); Jo et al. (2015)
Role play	Mallory (2003); Jo et al. (2015)
Audiovisual/multimedia-assisted	Kavanaugh et al. (2009); Smith-Stoner, 2011; Jo et al. (2015)
Online learning	Kavanaugh et al. (2009); Ellman et al. (2012); Gamondi et al. (2013b)

Reflective practice	Smith-Stoner (2011); Jo et al. (2015);
Art-based learning	Smith-Stoner, 2011; Jo et al. (2015)
Clinical practice	Von Rooyen et al. (2009); Chow et al. (2013); Gallagher et al. (2014); Edo-Gual et al., 2015; Van der Wrath et al. (2015)
Service learning	Jeffers (2014); Van der Wrath et al. (2015)

2.3.4.3 Competency and outcomes

Palliative care competency refers to the inclusion of extensive knowledge, attitudes and skills that are consistent with the provision of high quality EoLC (Gamondi et al., 2013). A number of key palliative care and EoLC competencies have been established by organisations from Europe (EAPC, 2010; NICE, 2011), America (ELNEC, 2015), Canada (CAHPC, 2011), Asia-Pacific (PCC4U, 2010; WHO Trivandrum, 2013) and Sub-Saharan Africa (APCA, 2014). However, these have been mainly developed for practitioners, and few apply directly to undergraduate students. These competencies are summarised in Table 5 below.

The American Association College of Nursing (AACN) has released the earliest reference for palliative care education for undergraduate nursing programmes called '*Peaceful Death: Recommended Competencies and Curricular Guidelines for End of Life Nursing Care', (*AACN, 1998). AACN and the City of Hope researchers subsequently developed a palliative care educational project for nurses (ELNEC) (Mallory, 2003). The ELNEC curriculum focuses on eight critical components of palliative care: introduction to palliative nursing, pain management, symptom management, communication, cultural considerations, ethics, loss, grief and bereavement, and care during final hours of life. This curriculum has been modified for graduate education, geriatrics, pediatrics, oncology, and for use with veterans (Ferrel et al., 2015). It has been integrated into national undergraduate core competencies in a range of countries (Wallace et al., 2011). However, it has been suggested that developing clinical learning outcomes using this curriculum requires further modification in order to accommodate local and contextual factors (Lippe et al., 2015).

A series of expert panels were organised by EAPC to develop guidance relating to palliative care education for European nurses (EAPC, 2010). Subsequent work by Gamondi et al. (2013a, 2013b) developed ten core competencies for palliative care. This was followed by a project which developed EoLC learning outcomes for health practitioners in the UK (Taylor et al., 2012). This process was informed by policy documents such as '*Common Core Principles and Competences for Social Care and Health Workers Working with Adults at the End of Life*' (Skills for Health and Skills for Care, 2014), '*Training Curriculum for Palliative Medicine (Amendments 2014)*' (Joint

Royal Colleges of Physicians Training Board, 2014), and '*Five Priorities of Care'* (The Leadership Alliance for Care of Dying People, 2014). Six domains of learning outcomes were identified by Taylor (2012): knowledge, communication and relationships, assessment, ethics and values, advance care planning, and personal and professional development.

Subsequent research has been conducted to evaluate the implementation of learning outcomes in practice and educational settings. In Australia, the Department of Health and Ageing (2005) funded the 'Palliative Care Curriculum for Undergraduates' (PCC4U) programme to improve the palliative care capabilities of the emerging Australian healthcare workforce (Hegarty et al., 2010). PCC4U (2012) offers an online learning platform emphasising assessment, symptom management, communication, care coordination and multidisciplinary teamwork.

Table 5 Summary of international core competencies related to EoLC

Domain	Authors
Knowledge about philosophy and policy in palliative care	ELNEC (2005); PCCC4U (2012); APCA (2010); Gamondi et al. (2013); WHO Trivandrum (2013)
Knowledge about trajectory of illness, dying and bereavement	ELNEC (2005); CAHPC (2011); Murray et al. (2015); APCA (2010)
Palliative care assessment	ELNEC (2005); PCC4U (2012); Taylor (2012); APCA (2010); Gamondi et al. (2013); WHO Trivandrum (2013)
Pain management and symptom management	ELNEC (2005); PCC4U (2012); APCA (2010); Gamondi et al. (2013); WHO Trivandrum (2013)
Nursing care plan	ELNEC (2005); EAPC (2010); Smith-Stoner (2011); WHO Trivandrum (2013)
Ethics and values	ELNEC (2005); EAPC (2010); Taylor (2012); APCA (2010); Gamondi et al. (2013); Connolly et al. (2014); NICE (2011); WHO Trivandrum (2013)
Decision making	ELNEC (2005); EAPC (2010); Taylor (2012); APCA (2010)
Advance care planning	Taylor (2012); NICE (2011); APCA (2010)
Care of imminent dying	ELNEC (2005); NICE (2011); Smith-Stoner (2011); APCA (2010)
Patient and family-centred care	ELNEC (2005); Smith-Stoner (2011); NICE (2011); Gamondi et al. (2013); WHO Trivandrum (2013); APCA (2010)
Evidence-based practices and outcome measures	ELNEC (2005); Taylor (2012); APCA (2010); Gamondi et al. (2013b)
Care of the dead body	ELNEC (2005); NICE (2011); Smith-Stoner (2011); WHO Trivandrum (2013)
Culturally sensitive care	ELNEC (2005); Smith-Stoner (2011); Connolly et al. (2014); Gamondi et al. (2013); WHO Trivandrum (2013); APCA (2010)
Spiritual care	ELNEC (2005); NICE (2011); Gamondi et al. (2013); WHO Trivandrum (2013); APCA (2010)
Communication	ELNEC (2005); EAPC (2010); 4CC4U (2012); Taylor (2012); Gamondi et al. (2013); WHO Trivandrum (2013); Connolly et al. (2014); APCA (2010)
Care coordination	ELNEC (2005); PCC44U (2012); APCA (2010); Gamondi et al. (2013); Connolly et al. (2014)
Promotion and education	ELNEC (2005); APCA (2010); Gamondi et al. (2013b)
Interdisciplinary teamwork	ELNEC (2005); EAPC (2010); PCC4U (2012), CAHPC (2011); APCA (2010)

Personal and professional development	ELNEC (2005); EAPC (2010); Smith-Stoner (2011); Taylor (2012); Connolly et al. (2014); APCA (2010)
Grief and bereavement support	ELNEC (2005); NICE (2011); Gerow et al. (2011); Smith-Stoner (2011); WHO Trivandrum (2013); APCA (2010)
Professional consultancy/referrals	ELNEC (2005)

Whilst the African Palliative Care Association (APCA) (2014) has published core competencies in palliative care to guide healthcare practice and education in Sub-Saharan Africa, few research studies overall have reported on dying and death education in resource-limitted settings (Bassah et al., 2014; van der Wrath et al., 2015). In Nigeria, Nwozichi et al. (2015) emphasised nursing students' need to learn to care for the dead body and to manage their emotional responses before entering clinical placements. Few publications have discussed PEoLCE in East Asia (Mok et al., 2002; Jo et al., 2015). In India, Shadu et al. (2010) reported medical and nursing students' lack of understanding of resuscitation, palliative care philosophy, symptom assessment and management, communication and interdisciplinary care for patients and families. WHO Trivandrum (2013) has published palliative care education for undergraduate nursing students in India, covering physical, psychological, social, cultural and spiritual dimensions. In Indonesia, AINEC (2016) has been developing a new undergraduate nursing curriculum document integrating PEoLCE. However, there have been no empirical studies to report this curriculum development and implementation.

Several countries have developed core competencies in PEOLC supported by national policies. Key competency domains identified include: knowledge, ethics, legal and moral issues, communication and relationships, psychosocial, cultural and spiritual considerations, patient and family as a unit of care, care of the dead body, grief and bereavement support, research and evidence-based practice. However, few documents have specifically mentioned clinical competencies in dealing with CDDB (Smith-Stoner, 2011; LACDP, 2014; NICE, 2015). Only one study mentioned a learning model for undergraduate students focused on care of the dying and after-death care (Smith-Stoner, 2011), and most documents do not mention specific core competencies and learning outcomes for undergraduate students. No national EoLC core competencies have been developed in Indonesia. The development and implementation of EoLC curriculum in undergraduate nursing programmes therefore requires further exploration.

The reviewed documents mention the importance of outcomes and behaviours resulting from the implementation of core competencies (Gamondi et al., 2013a; 2013b), which reflect the expectation of regulatory bodies towards professional education and health care practice (Gamondi et al., 2013b, p. 143). Findings further reveal that evaluations of educational and training interventions in dying, death and bereavement have often focused on participants' satisfaction with courses, and on changes in knowledge,

attitudes and behaviour, self-efficacy, self-competence and self-confidence among students and nurses (Cavaye et al., 2014; Bassah et al., 2014; Stephen et al., 2012). Other empirical studies have used self-efficacy in communication skills as outcomes of EoLCE (Bloomfield et al., 2015). Smith-Stoner (2011) argues that applying authentic learning assessment is important in comprehensively evaluating teaching and learning processes in CDDB. None of the studies used patient outcomes as a means of evaluating the impact of training on the quality of EoLC delivered.

2.3.5 Theoretical and models of frameworks in curriculum

End of life care practice and education is interconnected with multiple other disciplines, including sociology, antropology, psychology, medicine and nursing. Hence, no particular theory or set of theories has dominated this field. Studies have revealed that most scholars have drawn from adult learning (EAPC, 2010), cognitive and behavioral learning (Just et al., 2010; Bassah et al., 2014; Lippe et al., 2015; Jo et al., 2015; Ellman et al., 2016), and sociocultural and transformative learning theories (Mallory, 2003; Smith-Stoner, 2011; Bassah et al., 2014; van der Wrath et al., 2015). Few studies have described curriculum framework models (Gustafson et al., 1975; Boland, 1992; Leinburg, 2011; Kern et al., 2009). There are also limited nursing theories and models used to baseline classroom learning and clinical practice relating to CDDB (Carper, 1978; Chin and Kramer, 1998).

In the present study rather than being used to direct and guide the enquiry process, such theories were used to frame the interpretation (and, in some cases, re-interpretation) of the findings. These interpretations are further discussed in the discussion sections of Chapters 4, 5, 6, 7 and 9.

2.3.5.1 Cognitive and behavioral learning

As a part of cognitive and adult theory, Bloom's taxonomy of learning is often used when developing learning outcomes and objectives that include cognitive (knowledge), affective (attitudes), and psychomotor (skills) aspects (EAPC, 2010; AACN, 2015).

Cognitive learning theory underpins a spiral curriculum approach (Bruner, 1960), which emphasise three stages of learning: enactive, iconic, and symbolic. The key features of Bruner's spiral curriculum are enabling students to revisit learning content, increasing complexity with each visit, and new knowledge being shaped by old knowledge. PCC4U (2010) has successfully developed palliative care education for undergraduate health professional students, following a spiral and itirrative approach in which content is embedded in the whole curriculum over four years (Ramjan et al., 2010).

In medical education, Miller (1990) has extended Bruner's spiral curriculum by developing four levels of competency and achieving mastery: 'knows' (knows some

knowledge), ‘knows how’ (knows how to apply that knowledge), ‘shows’ (shows how to apply that knowledge), and ‘does’ (actually applies that knowledge in practice). Ellman et al. (2016) has successfully used Miller’s model to measure students’ competency after following interprofessional EoLCE by applying the Objective Structured Clinical Examination (OSCE) method.

2.3.5.2 Social transformative learning

Constructivist philosophy is an emerging approach to underpin end of life care education, which facilitates students obtaining knowledge, meaning and emotions, and inter-contextual realities about dying and death (Van der Wrath et al., 2015). As a form of constructivist theory, Kolb’s experiential learning (1984) is often used to baseline EoLCE (Cavaye et al., 2014; Bassah et al., 2014). Experiential learning allows students to reflect on their teaching via a combination of previous experiences, either in the classroom or clinical environment, and teaching strategies (Kavanaugh et al., 2009; Bassah et al., 2014; van der Wrath et al., 2015). Other principles that can be applied in framing a curriculum are: social cultural learning (Vygostky, 1956), which emphasises experiences, social interaction and engagement, and transformative learning (Mezirow, 1991), which covers frame of reference, critical reflection, dialogues, motivation and self-determination (Mallory, 2003). Such processes can further faciliate the transformation of students’ habits of mind and points of view by having different learning opportunities that trigger their critical thinking and reflection ability (Mezirow, 1991; Mallory, 2003; Smith-Stoner, 2011). In essence, constructivist learning theories support learning-based experience which provides real-life context that can enable students to construct new knowledge as well as to apply such understandings to their future practice (van der Wath et al., 2015).

Sociocultural theories were first developed and applied by Vygotsky and his associates in Russia in the 1920s and 1930s. Sociocultural theories accommodate the development of cognitive aspect that can be facilitated through social interaction between an individual with other people, objects and events (Johnson, 2009). Therefore, social, cultural and historical contexts cannot be separated from the process of human cognitive development in which all contextual aspects emerged and are used (Johnson, 2009). Furthermore, social and cultural engagement is mediated by culturally-constructed tools such as language, materials, signs and symbols that create uniquely human forms of higher-level thinking. In his well-known genetic law of development, Vygotsky emphasised the primacy of social interaction in human cognitive development in which human mental abilities emerge twice: “first, on the social level, and later, on the individual level; first, between people (interpsychological) and then inside the child (intrapsychological)” (Vygotsky, 1978, p. 57). Based on this perspectives, there are two types of learning and development processes can occur: first on the social aspect

(through interaction with others) and then on the psychological aspect (within the learner). This describes a process of human cognitive development which is situated in, but not limited to, social interaction (John-Steiner & Mahn, 1996 cited in Johnson, 2009). Nurses are therefore expected to recognise the multi-dimensional needs of the dying patients and their families, and thus plans to deliver appropriate care using such knowledge.

Mezirow (1994) asserts that experience is influenced by personal and professional experiences, situations connected to the learning environment, and societal factors. Promoting discussion, critical reflection, interaction and transformative action is thus necessary in the context of the EoLC curriculum. However, in the nursing literature, little has been written about either the principles of sociocultural and transformative learning and how to apply them in the EoLCE research. Few nursing studies focusing on EoLCE have used transformative learning principles (Mallory, 2003; Smith-Stoner, 2011, van der Wrath et al., 2015). According to Mezirow (2009), the acknowledgement of personal and aesthetic knowing is the foundation aspect of holistic orientation in teaching and learning. He further suggests an individual's experiences are composed by affective knowing and emotions, which often stimulate reflection and transformation of beliefs, attitudes or perspectives. As a part of critical pedagogy, transformative learning helps students to appreciate the beauty, complexity, challenges and grief associated with dying and death (Smith-Stoner, 2011). Finally, Mezirow (2009) proposes an authentic relationship that generally referred to teacher and learner. Thus, establishing meaningful relationships between nurses and patients is an important agenda during undergraduate training.

2.3.5.3 Nursing theories and models

The literature review carried out identified key nursing theories, including patterns of knowing (Carpers, 1978; Chin and Kramer, 1998 cited in Smith-Stoner, 2011 and Todaro-Franceschi et al., 2014), and novice-to-expert theory (Benner, 1984 cited in Johnston et al., 2006; Thacker, 2008). The constructivist worldview in EoLC theory and practice in nursing is supported by 'ways of knowing' (Carper, 1978), built on empirical, personal, aesthetic and ethico-legal knowledge. Carper's theory was subsequently criticised by White (1995) due to its limitations in capturing the critical reflective practice which underlines individual transformation of actions. In response, Chin and Kramer (2010) proposed an additional construct of social-political or emancipatory knowing, as the fifth 'pattern of knowing', representing a transformative worldview. Smith-Stoner (2011) developed the 'Silver Hours' model to guide classroom learning and clinical practice surrounding EoLC. This model emphasises the use of 'Pattern of knowing' theory (Chin and Kramer, 1998) to guide students and nurses to implement care

processes, from the point of admission right through to the removal of the patient's body from the location of death.

Pattern of knowing consists of knowledge within empirical, aesthetic, ethical and legal, personal, socio-political and emancipatory dimensions (Carper, 1978; Chin and Kramer, 1994). Empirical knowledge focuses on scientific knowledge and objective facts which baseline proper assessment and symptom management at the end of life (Kennedy, 1998). Aesthetic knowing further refers to finding meaning and significance in EoLC. Ethical and legal knowledge includes nurses' responsibility and justification for clinical decision-making (Kennedy, 1998; Smith-Stoner, 2011). Personal knowing focuses on the therapeutic use of self as well as socio-political understanding. It discusses the personal and professional boundary of EoL and cultural differences which may help nurses improve EoLC for the patient (Smith-Stoner, 2011). Emancipatory knowing underlines the development of empowerment strategies to minimise gaps in current EoLC practice and education (Smith-Stoner, 2011). Overall, multiple ways of knowing, which reflects nursing ontology and epistemology, are necessary. Such nursing philosophy has made a major contribution to the development of palliative and end of life care practices and education.

The reviewed studies highlight that end of life care requires specific knowledge and skills that should be obtained during undergraduate training (Cavaye et al., 2014; Lippe et al., 2015) and clinical nursing practice (Baker et al., 2013). Novice-to-expert theory (Benner, 1982) was used to underpin students' and nurses' professional development in palliative and end of life care (Tacker, 2008; AACN, 2015; Pope, 2013). Benner's theory was developed following the Dreyfus and Dreyfus's (2001) skills of acquisition model in military areas. This theory focuses on how nurses acquire nursing knowledge and skills, divided into five levels: novice, advance beginner, competent, proficient, and expert.

Benner (1982) suggests that expert nurses develop skills and understandings of patients over time through an appropriate, planned and contextualised educational environment, as well as via an array of experiences (Johnston et al., 2006; Thacker, 2008). In contrast to expert nurses, novices learn how to provide care through guidance and prescribed standards (Thacker, 2008). Although Benner's novice-to-expert model is often used to baseline nursing practice and education, the model contains a lack of objectivity due to its subjective nature (English, 1993 cited in Pope, 2013). However, Darbyshire (1994) argued that Benner provides insights to support the development of clinical judgement, critical thinking and intuition during a nurse's career. Benner's work constitutes a philosophy rather than a theory, which illustrates the complexity of nursing practice and variety of experiences that enhance nursing practice (Altman, 2007). Whether considered a theory or a philosophy, researchers share an agreement that the

novice-to-expert model can be fitted into nursing curricula and practice implementation (Altmann, 2007; Darbyshire, 1994; Pope, 2013).

Likewise, Miller's construct of competency assessment is similar to Benner's 'novice-to-expert' construct. Ellman et al. (2016) used Miller's pyramid model to evaluate an interprofessional end of life care education programme. They used OSCEs to assses knowledge and skills, combined written objective tests and clinical simulation-based performance. Both theories reflect a spiral learning approach (Bruner, 1960) and resemble zones of proximal learning (Vygostky, 1978). These theories further emphasise that the development of knowledge and skills should be based on the student's learning journey and their level of understanding, which starts from a simple-to-complex learning situation (Johnston, 2012).

2.3.5.4 Curricular design model

The literature reveals that the process of curriculum design requires systematic guidelines. Few studies have discussed curriculum models to develop undergraduate nursing education and CDDB training, particularly in resource-limited settings. Those models identified include the COPA (Competency Performance Assessment) model (Leinburg, 2011), the ADDIE (Analysis, Design, Development, Implementation, Evaluation) model (Gustafson and Branch, 1975), and the Six-step approach (Kern et al., 2009).

As a form of constructivist model, the COPA framework focuses on a learner-centred approach and competency-based learning (Leinburg, 2011). This was used to develop competencies in the area of HIV-AIDS care, and integrated these competencies into an existing undergraduate nursing curriculum (Modeste, 2015). As another constructivist model, the ADDIE also reflects a learner-centred approach, focusing on solving practical problems through learners' exhibiting meaningful actions and via measurement of specific outcomes. However, the ADDIE model has been criticized as being limited and static (Allen et al., 2012). Only one study used this model to develop death education for nursing students in Korea (Son-Hee et al., 2015), although nurse educators were not included in this study.

Pragmatism acknowledges the constructivist approach to defend the progressive building of cognitive structures of individuals (Dewey, 1981; Garrison, 1995; Kavanaugh et al., 2009), and this knowledge results from the interaction between the subject and the environment (van der Wrath et al., 2015). Studies reveal that Dewey's pragmatism underpins end of life care education (EoLCE) in health professional education settings (Kavanaugh et al., 2009; Just et al., 2010; Bassah et al., 2014). The studies demonstrated the development of EoLCE within high-resource and limited-resource contexts. Two studies (Just et al., 2010; Bassah et al., 2014) used Kern's cyclical model as a process guide to develop a new course and learning modules following their

existing curricula. None of the studies used Kern's model to promote CDDB among undergraduate nursing students in developing countries.

As a pragmatic model, Kern's six-step approach was originally a medical curriculum model representing different, interlinking aspects required to create a new curriculum or course, as well as to revise an existing curriculum. Kern et al. claim this cyclical model has extended previous curriculum models (Tyler, 1954; Taba, 1976) and needs assessment models in nursing education (Yura and Tores, 1985). Kern's six-step approach is a stepwise model with interrelated processes (see figure 3).

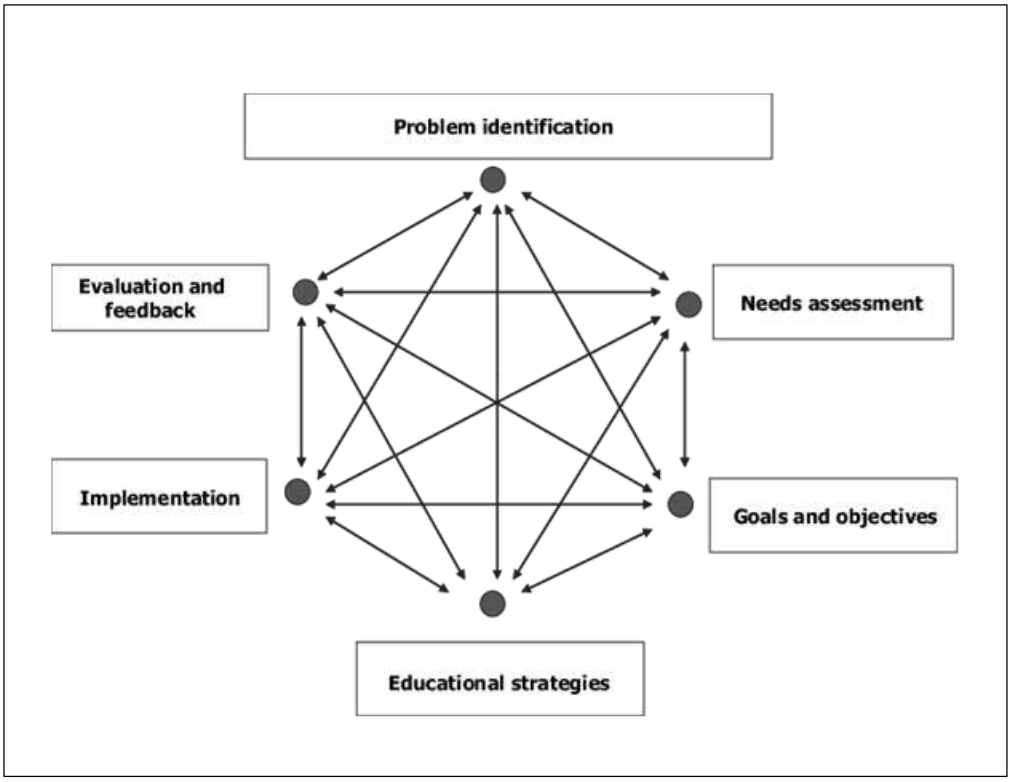

Figure 3 Six-step approach to curriculum development

Source: Kern et al. (2009, p. 6)

During the problem identification phase (step 1), four critical questions can guide the data collection process: 1) What is currently being done by the participants?; 2) What personal and environmental factors affect problems?; 3) What ideally should be done by those participants?; and 4) What are the critical differences between the current and ideal approaches? (Kern et al., 2009, p. 15). Furthermore, in step 2, a targeted needs assessment, multi sources and methodologies can be utilised to determine the needs of the stakeholders. Subsequently, curriculum developers focus on proposing goals and objectives (step 3) and finding suitable pedagogy and teaching practice (step 4). Finally, further implementation of the curriculum (step 5) is an important stage, which requires ongoing evaluation (step 6) in order to identify common pitfalls and reconstruction of the curriculum (Kern et al., 2009).

Kern et al. (2009) point out that curriculum development does not usually proceed in sequence or follow step-by-step actions. They further state that the curriculum is dynamic and entails continuous interactive and interconnected processes. Thus, the curriculum evolves based on evaluation results, changes in resources, targeted learners, and the materials requiring mastery. A systematic and flexible curriculum development process is therefore required to accommodate varying educational contexts, organizations, and learning environments (Kern et al., 2009). In essence, the WHO (2010) stresses the importance of developing healthcare programmes according to the health needs of the population and the functions of healthcare practitioners. Whilst it is important that curricula should be relevant to stakeholder needs, it is also important to take cognisance of the methods used to identify these needs (Bligh et al., 2001 in Kern et al., 2009). Future curriculum studies will need to involve multiple stakeholders, and to evaluate existing curricula in order to rationalise current teaching and learning practices.

2.3.6 Gaps identified in the literature

The aim of this review was to explore the literature on EoLC and CDDB and undergraduate nursing programmes. The absence of a universal or shared definion of CDDB in nursing is an issue in its own right, discussion of which is beyond the scope of this review.

In more than two decades, there has been a proliferation of publications on learning experiences that foster education and training development in care of the dying and death in nursing. However, there is a paucity of evidence examining the experiences of CDDB from multiple perspectives. Reviews have also highlighted a number of studies that have used non-standardised methods of evaluating the effectiveness of dying and death education. From this review, it is apparent that there is a dearth of quality evidence specifically addressing CDDB and pre-registration nursing education. The major gaps identified are as follows: 1) care of the dying, dead and bereaved as a personal experience, which is non-explicit in the curriculum; 2) a lack of multi-perspective viewpoints; 3) unclear philosophical orientation and lack of integration in teaching and learning; 4) constraints relating to support and facilitation; and 5) lack of curriculum structure and unpreparedness of teaching faculties.

The majority of studies have used pre-established international frameworks (EAPC, 2010; PCC4U, 2012; ELNEC, 2015) or national guidelines (APCA, 2010; WHO Trivandrum, 2013) to develop palliative care education. Few have reported the process of developing the curriculum of palliative care and EoLC education in undergraduate nursing programmes. In addition, bereavement care appears to be lacking across pre-established health professional training frameworks where there may be opportunities to enhance or initiate delivery of relevant topics, courses, and continuing professional

development interventions (Stephen et al., 2012). Hence, creating an applicable curriculum framework is essential in improving the quality of undergraduate nursing education, particularly in resource-limited settings (Jayasekara et al., 2013). No reported studies have thus far discussed the curriculum process and implementation of CDDB in nursing programmes.

The majority of studies have used established curricula to deliver EoLCE for undergraduate students, which may not represent the social cultures, values, beliefs and needs of dying patients and their families, particularly in developing countries. There are also differences in the types of undergraduate education available, the methods used by nurse educators in teaching and learning delivery, and the utilised regulatory frameworks. The influence of curriculum design needs to be considered when translating the findings into practice in different contexts and situations. Conducting a needs assessment is therefore essential to capture these fundamental aspects in the development of a curriculum (Kern et al., 1994). Reviewing regional and national educational initiatives and policies can illuminate the current status of EoLCE and CDDB, particularly in resource-limited settings. The majority of studies have not included both students and faculty members, and the involvement of both of these parties is important when undertaking needs assessments.

2.3.7 Implications of study

Dying and death education has been evolving since the modern hospice and palliative care movement era, from an unstructured educational agenda to a more structured programme and unplanned relevant learning experiences that occur in the educational process. The nursing curriculum is blended with the ontology and epistemology of nursing practice and supported by various learning and motivational theories. The curricular developers are thus expected to predict the future while developing curricular framework so that it may give opportunities for nurse educators to accommodate global, regional and local contextual issues. Without an effective and meaningful curriculum, students are not able to understand or meet the challenges of society, and nurse educators need to have knowledge and skills in developing adequate teaching and learning activities in EoLCE and CDDB.

The reviewed studies demonstrate an absence of focus on continuity of classroom learning and clinical placement experience as part of the teaching and learning process, and a lack of student and nurse educator perspectives on EoLCE. The findings indicate that education and training related to CDDB has often been created on an *ad hoc* basis, despite the fact that many students and nurses rely on institutional support to improve their knowledge and skills in CDDB. Few studies have been carried out on how CDDB might be integrated in the existing undergraduate nursing curriculum.

The development of knowledge and skills in CDDB may be facilitated through pre-established programmes and increased awareness of the need for experiential learning in EoLC. However, there is a lack of research on the clinical teaching of student nurses, especially research focusing on educating students in caring for dying patients and delivering after-death care. An understanding of how nurse educators utilise the classroom, clinical setting, patient assignments and teaching strategies would be valuable. Research that combines both pre-clinical and clinical education would also add to the knowledge-base relating to nursing.

2.4 Conclusion

Overall, limited educational frameworks exist for the incorporation of CDDB within the undergraduate nursing curriculum. The pre-established structures have been established in Western countries, with specific healthcare and educational settings and particular social, economic, political, cultural and environmental contexts. Limited educational frameworks and models exist to facilitate integration and assessment of CDDB for undergraduate nursing students in non-Western countries, and limited literature exists on barriers and facilitators to the development of CDDB in nursing education in non-Western contexts, particularly in Indonesia.

Previous studies have further revealed a lack of clear terminology relating to dying and death education (which is often associated with palliative care and/or end of life care education) (Cavaye et al., 2014). Almost no literature has provided an agreed definition of CDDB. Accordingly, for the purposes of this study, the definition used by Smith-Stoner (2011) has been adopted: that is, “care provision during the dying phase, death and after-death events involving the patient and their family as a core unit.”

Kern’s six-step approach was utilised in a wide range of curriculum studies that included multidisciplinary contexts. This model provides a structure by which to identify and analyse influences, and promotes an iterative process in curriculum development (Kern et al., 2009). Such situations give opportunities for curriculum developers to apply the model either in developing the new curriculum/courses or revising them. This appears particularly apt for the present study, since the aim is to develop a curriculum framework built on the existing educational system. Kern’s model will therefore be utilised to guide the process of the research, as discussed in chapter 3. Furthermore, this research is intended to fill this gap by providing a brief overview of sociocultural and transformative learning, and introducing the way in which they can be used in the CDDB curricular design (see chapter 7).

Based on the findings of the literature review, the research questions were partially revised. The amended research questions may be summarised as follows:

1. What is already known about CDDB in current undergraduate nursing programmes in asian settings?
2. What are the perceptions, experiences and needs relating to CDDB in the learning environment?
3. What is the suggested curriculum content of CDDB in undergraduate nursing programmes in Indonesia?
4. How is curriculum content best structured and delivered within undergraduate nursing curricula to support the provision of CDDB in Indonesia?

The following chapter presents the research methodology to address these research questions.

3 Research Methodology and Methods

3.1 Introduction

This chapter presents the research methodology adopted in this study and provides a rationale for the methods of data collection and analysis used, according to the study aims, research questions and objectives. The ethical procedures followed in conducting this research are explained, and the limitations of the data collection methods are highlighted

3.2 Research methodology

Methodology is the way in which the research process is conducted in relation to questions and context and may be distinguished from methods which are the specific techniques and procedures used to collect and analyse data. Researchers seek to translate pragmatic epistemiological concerns into relevant research methodology and to make appropriate decisions on research methods. In establishing the research paradigm underpinning the present research study, Crotty's (1998) framework was used to explore and summarise various research paradigms. In utilising this framework, I reflected on my own practical worldview and situational response (ontology), which inclined towards critical ontology and pragmatist epistemology (Brown, 2016).

3.2.1 Pragmatism as a research paradigm

The theoretical values underpinning this study may be described as reflecting a pragmatist paradigm (Dewey, 1981; Garrison, 1995; Feinberg, 2012; Forester, 2013; Morgan, 2014). Pragmatism is a 'philosophical stance that embraces multiple viewpoints of a research problem' (Andrew and Halcomb, 2009 cited in Brown, 2016). Pragmatism places an emphasis on an instrumental view of knowledge, such that knowledge is considered to be utilized in action in order to make a purposeful difference in practice. The notion of pragmatism is connected with constructivist philosophy, involving the process of knowledge construction through meaning-making and interaction. However, whilst the meaning of an idea or concept and its practical consequences are at the core of pragmatism, the pragmatist approach does not consider actions to be superior to knowledge or practice to be superior to thoughts (Dewey, 1981). Rather, the approach emphasises the integration of thinking and acting as well as the involvement of the mind to reflect on how acts generate genuine knowledge.

Dewey's pragmatism further resonates with the idea of democracy that demonstrates critical perspectives towards power and authorities, which had influenced Habermas' theory of knowledge and communicative action (Garrison, 1995; Feinberg, 2012; Forester, 2013). Such pragmatism also involves the theory of planning, which offers a

hopeful, action-oriented direction for planning that is flexible and historically- and contextually-rooted (Forester, 2013). Pragmatism does not take a dogmatic position concerning methods adopted in research, but rather a pluralist approach (Goles and Hirscheim, 2000), involving utilisation of combinations of techniques and methods that are suitable in the context of the particular research design and study questions (Garrison, 1995; Brown, 2016). Pragmatism allows the researcher to recognise different layers of a phenomenon and also to interpret and measure the phenomenon.

Knowledge about dying, death and bereavement is built up from experiences that include physical, psychological, social, cultural and spiritual aspects, each of which influence individuals' perception, knowledge, and experiences in caring for the dying, dead and bereaved in the context of clinical practice. Essentially, from a pragmatic perspective, CDDB is a competency-based practice which requires extensive knowledge and technical and procedural skills. However, in the context of dying and death, people's experiences of this process are personal and unique to individual patients, families, students and practitioners. Moral invention becomes another important aspect which should be considered, particularly when dealing with ethical dilemmas in health care practice (Feinberg, 2012) which may challenge health professional agency to consider the best option given to the dying patient and their family. Within the complexity, uncertainty and diversity of CDDB practice, there is a need of an individual to consider whether a belief should continue to serve as a guide to her or his action (Feinberg, 2012). Thus, a good moral invention can be considered as a way to resolve the tradition of absolutism with a flexibility of relativism (Feinberg, 2012). Although such moral invention does not always ends a controversy (p.8), it can guide practitioners to find other pathways that may provide better results.

As a researcher, I found that education about dying, death and bereavement research focuses on students or practitioner nurses, and thus rarely runs towards exemplary nurse educators (Brien et al. 2008; Jeffers, 2013; Todaro-Franceschi et al., 2012) and decision makers (Johnson, 2009). There is also a fragmented orientation which leads to disconnection of education, practice and research in CDDB. Findings of many research themes and results have often been less relevant to the classroom learning. I believe that educational research in nursing areas should consider the realities of the classroom and clinical practice. Hence, curriculum developers and educational researchers should vigorously search for students, educators and practitioners' input and value their contributions when developing the curriculum.

Pragmatism has been long recognised as a philosophical foundation of liberal and progressive education (Garrison, 1995), and has been adopted by outcome-based education (OBE) (Kavanaugh et al., 2009; Ornstein et al., 2017). In the context of curriculum development, the process involves multiple ways of knowing for seeking the truths, with the curriculum represented as process, method and product of knowledge

construction. Knowledge in the curriculum is constructed from meaning-making and interactions within multifaceted settings. Multiple factors thus need to be considered in curriculum development, including social, culture, economic, political, environmental, historical and geographical aspects (UNESCO, 2012). To this purpose, attention needs to be paid to relevant history, individual experiences, existing facts, conditions and systems (Godlkuhl, 2012). Pragmatism thus holds that research occurs in social, historical, political, and other contexts, and contemporary researchers working within the pragmatic paradigm are also reflective of social justice and political aims (Borgeuis, 2010; Creswell, 2014; Forester, 2013). Pragmatism further acknowledges multiple values and uncertainty, acknowledging that ethical positions need to be situated within contexts and may potentially be revised on the basis of experience (Feinberg, 2012).

Pragmatism allows the researchers to have freedom to select the best approach to answer their research questions (Clarke and Visser, 2019). Despite qualitative research favours no one methodology over another (Denzin and Lincoln, 1994), pragmatism has lack of theoretical and philosophical rigours. Pragmatic methodology can further challenge the quality standards of a study (Clarke et al., 2019). In order to counter such criticisms, there are several key areas that must be considered to enhance the credibility of pragmatic research as proposed by Caelli, Ray and Mill (2003, p.5) cited in Clarke et al. (2019) as follows:

> *'…the theoretical positioning of the researcher; the congruence between methodology and methods; the strategies to establish rigor; and the analytic lens through which the data are examined.*

The pragmatic paradigm was adopted in the present thesis because its philosophical and methodological pluralisms (Garrison, 1995) allowed me to make choices about the study design as well as the research process based on what works best for answering the research question on the exploration of perception, experiences and needs of CDDB in the learning environment and how to structure a curriculum framework of CDDB that fits in the context of current nursing educational setting. Reflecting my theoretical position, I therefore consider Dewey's critical pragmatism which claims the truth of knowledge about curriculum can be obtained through reflection, dialogues, action and criticism. These are powerful methods to construct knowledge by considering multiple dimensions in the field of education (Forester, 2013). Accordingly, critical pragmatism allows that everyday understanding is sometimes inadequate in defining a situation as problematic; especially in cases where power and experience is unequal (Forester, 2013). Critical pragmatism also encourages an ongoing dialogue between refined research and everyday understanding about systematic silences (Feinberg, 2012, p.9) that often considers CDDB as an intangible practice and learning. Thus, critics and dialogues are essential for exploring the causes of problems and seeking the best solutions within EoLC practice and education.

Finally, the pragmatist approach endorses eclecticism and pluralism in methodology: both qualitative and quantitative methods are compatible with the pragmatic paradigm (Garrison, 1995; Morgan, 2014). The present study conducted within the critical pragmatism paradigm (Forester, 2013) applied a qualitative multimethod research design (Bender, 2011; Brown, 2016; Orsolya, 2019) to explore stakeholders' perception, experiences and needs about care of the dying, dead and bereaved in learning environments. The aim was to generate themes for developing the curriculum framework grounded in the realities of the classroom and clinical practice as well as to support policy, education, and practice in the area of end of life care. Details of the study design are discussed in the next section.

3.2.2 Qualitative multimethods study as a research design

The goal of qualitative description is to generate a summary of everyday events experienced by individuals or groups of individuals (Sandelowski, 2010). Qualitative description is considered a feasible and acceptable qualitative research design (Lambert and Lambert, 2012), which can capture multiple realities of the social world (Morgan, 2014). Qualitative descriptions typically emphasise people's characteristics, circumstances, and the nature of phenomena, and can enable researchers to modify research questions as new information arises (Polit et al., 2012).

Pragmatist researchers often use mixed methods or multimethod designs in their inquiry by using a combination of different research strategies (Bryman, 2008; Morse, 2010; Creswell, 2014; Heise-Biber et al., 2017). Mixed methods research is defined as 'a systematic approach to addressing research questions that involves collecting, analysing and synthesising both quantitative and qualitative data in a single research project' (Andrew et al., 2009 cited in Brown, 2016). Mixed methods are considered an emerging research design in healthcare practice and nursing education (Brown et al., 2016).

However, researchers may also use *multimethod* designs, which allow them to obtain a more complex picture of human behaviour and experience (Bryman, 2008; Morse, 2010). A multimethod design has been defined as a series of complete related qualitative and/or quantitative studies with different research questions, which are complementary to the overall aim of the research (Morse & Niehaus, 2009). As distinct from mixed methods research, multimethods research designs aim to use the findings from one research method to develop or inform another research method (Morse, 2010). Heise-Biber et al. (2017) assert that multimethods research can employ different approaches to address an overall research goal, using either a qualitative, quantitative *or* mixed methods approach.

Multimethod designs may be categorised into simultaneous or sequential, qualitatively- or quantitatively-driven (Morse et al., 2009). Morse (2010) makes a distinction between

core (QUAL) and supplemental (qual) components of qualitative multimethods studies, whereby the former constitute a complete method, whilst the latter complement the previous research and do not constitute a stand-alone study. This supplementary research may be either simultaneous or sequential, depending on the research questions to be answered (Phillips et al., 2014; Brown et al., 2016; Orsolya, 2019). Morse (2010) states that the data types, levels of analysis, and participant perspectives of the core and supplementary components need "to be handled differently and to be kept apart" (p.491).

In simultaneous designs, the various methods applied are used concurrently: one method forms the basis of the emerging theoretical scheme, while the second is designed to elicit information that the first method cannot achieve. In sequential multimethod designs, the base study is conducted first, while the second method is planned to resolve problems and issues uncovered by the first one or to provide a logical extension to its findings (Orsolya, 2019).

In addition, research implementing multimethod designs may be either quantitatively or qualitatively driven. Qualitatively-driven multimethod projects have an inductive drive, and are used for developing descriptions or deriving the meanings of phenomena. Quantitatively driven multimethod designs are deductive in nature, and are used primarily for testing of hypotheses or theories (Morse, 2003; Morse et al., 2009).

A pragmatic methodology, utilising a qualitative multimethod approach (Morse et al., 2009; Bender, 2011; Brown, 2016; Orsolya , 2019), was adopted in this study. This allowed a focus to be placed on the perceptions, experiences and learning needs of nursing students and nurse educators, and existing curriculum regarding CDDB. Curricula and curriculum development are potentially influenced by a variety of factors and may be viewed as a social construction (Adams, 2011). The consideration of such social and cultural constructions has implications for this study, since the knowledge that guides curriculum development is continually influenced by the perceptions, prior experiences and knowledge of different stakeholders (students, nurse educators and practitioners).

Given its complex nature, developing a framework focused on care of the dying, dead and bereaved in undergraduate nursing education lends itself to applying a multimethod approach to research. This allows a more thorough and comprehensive investigation of the phenomena. In the present study, a qualitative multimethods sequential design was utilized, reflecting a pragmatic approach within a natural setting used to answer the research questions. As described in section 2.5, four research questions were developed, with questions of '*what'* assigned to address questions one, two, and three, and questions of '*how'* applied to question four. The research process is outlined in Figure 4.

The research comprised four sequential stages, each of which corresponds to one of the key research questions as above. Stage 1 comprised a scoping review of the curriculum in undergraduate nursing education in Asian countries. In stage 2, the perceptions, experiences and needs of students and nurse educators in relation to CDDB were explored. Semi-structured interviews were conducted with individual nursing students and nurse educators to assess their personal experiences and learning needs. This stage also explored perceived barriers and facilitators relating to CDDB in clinical teaching and learning. Stage 3 focused on identifying how CDDB is included in the current undergraduate curriculum in one faculty of nursing in Indonesia. In order to explore how the actual and ideal curriculum should be generated, a curriculum mapping exercise was used to review an exemplar of undergraduate nursing curriculum. A focus group discussion was also held to explore key stakeholders' opinions about the actual practice and best practice of CDDB in academic and practice settings. This method aimed to triangulate the findings of the faculty curriculum review. In the final stage (stage 4), the data arising from the previous research questions were analysed and used to generate the framework of a contextual curriculum. An evidence-based and theory-driven framework was developed, following the principles of transformative learning and social-cultural theory.

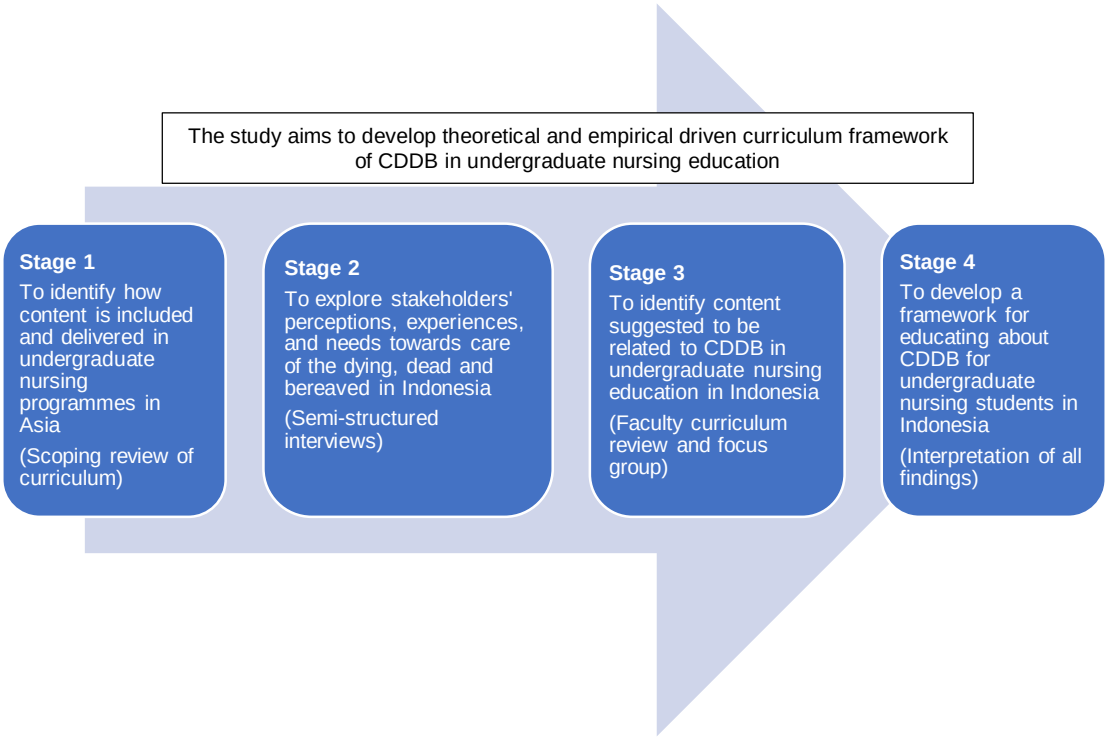

Figure 4 The four stages of qualitative multimethods study

As shown in Figure 4, in order to implement the selected design, four sequential studies were conducted. The findings and implications of these studies are presented separately in Chapters 4, 5, 6 and 7, while reflexivity of the study, overall conclusions and recommendations are presented subsequently in Chapters 8 and 9,.

3.2.3 Conceptual framework of the study

As well as taking a pragmatic approach towards understanding the nature of nursing practice and education in Indonesia, this research also adopted the iterative approach of Kern's model (see section 2.4.4.3), using a modified six-step approach to curriculum development (Just et al., 2010; Bassah et al., 2014; McCartney et al., 2016) to guide the research process. Kern's model was modified following McCartney et al. (2016) to develop a conceptual framework as a process guide.

All steps of the process were categorised into three cycled phases: Phase 1 identified the elements of curriculum and framework development (Kern's steps 1 and 2); phase 2 developed the curriculum and instructional design (Kern's step 3 and 4); and phase 3 covered implementation, evaluation and maintaining sustainability (Kern's step 5 and 6). Figure 5 below describes the modified Kern's model.

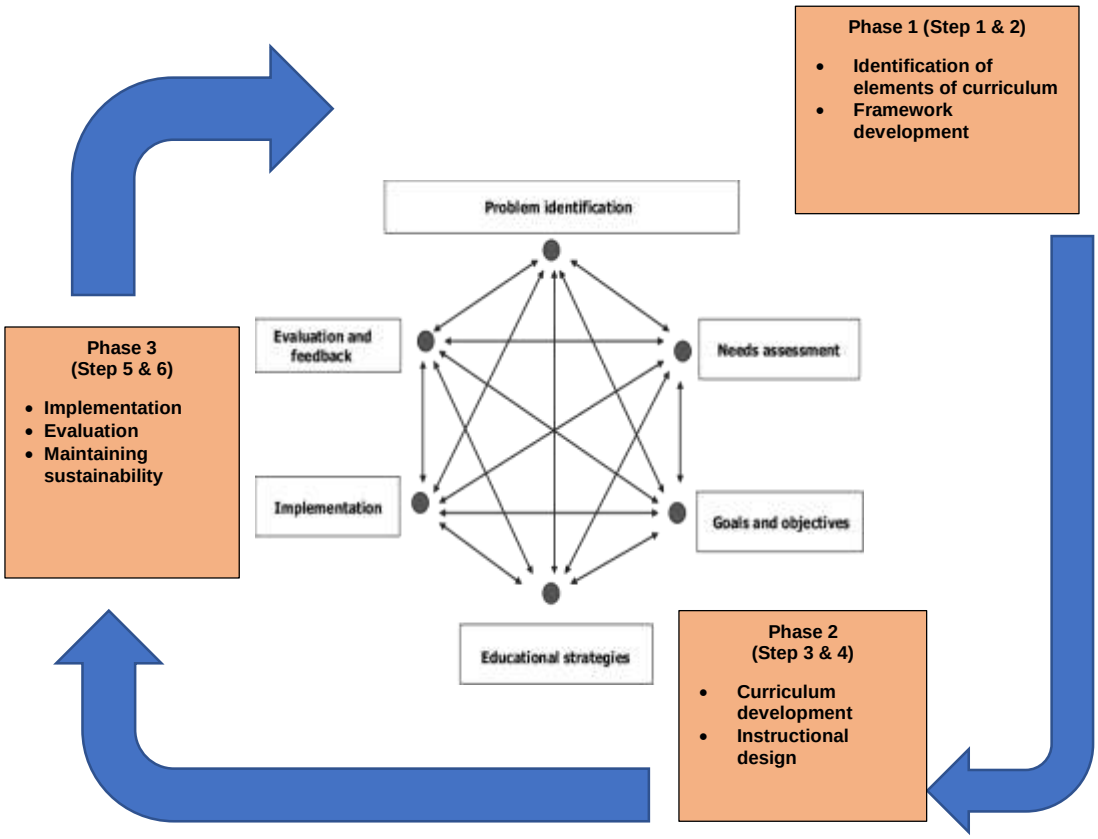

Figure 5 Modified Kern's Six-Step Approach (Kern et al, 2009; McCartney et al, 2016)

This study focuses primarily on phase 1 of the modified Kern's model (McCartney et al., 2016) – that is, identifying the basic elements of curriculum content, based on multiple data sources obtained using multiple methods, and analysing data to generate core elements that support the curriculum framework development.

3.3 Research methods

This section provides an overview of the data sources and sampling methods used, and the data collection and analysis methods used in each phase of the study. I used COREQ guidelines as a systematic framework in reporting the research process and findings of this study (see Appendix L). Detailed methodology and findings are also described in Chapters 4, 5 and 6.

3.3.1 Scoping review of Asian nursing curricula

The first stage of the study addressed research question 1: "How is CDDB included and implemented in current undergraduate nursing programmes?" This stage aimed to identify curriculum content relating to CDDB for undergraduate nursing education in the Asian context. Further description about methods used in the stage 1 of this study is presented in chapter 4.

3.3.2 Semi-structured interviews with pre-registration students and nurse educators

The second stage of this study addressed research question 2 'What are stakeholders' perceptions, experiences and needs of CDDB in the learning environment?'. Semi-structured interview was used as a primary method of this study. Such interviews were conducted to assess participants' perceptions and experiences, using open-ended questions and a semi-structured format (Allbright et al., 1998). These interviews formed the fourth and final study of this PhD thesis, which presented in Chapter 7 and 9. Detailed information on the interview guidelines is presented in Appendix A.

The objectives of the semi-structured interviews were: (a) to explore the perceptions, experiences, and needs of undergraduate nursing students, faculty staff and clinical instructors in relation to caring for people at the end of life, and how they relate these perspectives to teaching and learning; (b) to explore nurse educators' perspectives about barriers and facilitators relating to caring for people at the end of life in learning environments. Fundamental qualitative description was therefore chosen as a method to provide comprehensive summary of a phenomenon within everyday situations (Sandelowski, 2000; Bender, 2011).

To achieve these objectives, an interview guide was developed containing questions representing broad categories, as proposed in steps 1 and 2 of Kern's model (see section 2.4.5.4) The pilot interview guide was tested with five nurse educators prior to

use (see Appendix A). Pilot results indicated that participants comprehended the interview guide instructions and questions, and that interviews typically lasted between 30 and 60 minutes. Data saturation was believed to occur around two thirds into data collection process.

3.3.3 Faculty curriculum mapping

The third stage of the study addressed research question 3: 'What are suggested curriculum content of CDDB in undergraduate nursing programmes in Indonesia?'. This question was intended to explore essential components to build a curriculum on CDDB for undergraduate nursing students.

A curriculum mapping exercise (Wachtler et al., 2003; Rower et al., 2015) was carried out in order to identify the planned, intended, and received (taught) curriculum. Rather than studying all nursing schools in Indonesia, an exemplar of national curriculum implementation in a state university was selected. As described in Chapter 2, a national curriculum text was previously created to guide the curriculum design and enhance the quality of nursing education in Indonesia (AINEC, 2010, 2016). Curriculum mapping allows faculties and administrators to capture any missing or overlapping content from the points of origin (national curriculum text) towards the endpoints (taught curriculum or modules) (Harden, 2001). Variations in curricula are often due to personal, organisational and environmental factors which divert the curriculum from the original contents (Harden, 2001; Gysels et al., 2013). A document review was carried out, involving collecting course study guides for students in the academic programme (years 1 to 4) and clinical learning guides for internship students (year 5).

The clinical learning guidelines that were studied had been annually revised and published for students entering the internship programmes during the selected years (FON Unpad, 2012; 2017). Whilst there are no standard guidelines on using document reviews as part of the data collection process or how to systematically analyse such documents, many previous studies have used documents as primary data sources (Bowen, 2009). In the present study, only documents that were part of the public record, with proven authenticity (as described by Bowen, 2009) were used in the document analysis. This study mapped the content of the curriculum from the 2010 to 2015 period and the new curriculum of 2015. The planned new curriculum content of 2015 for academic year of 2017/2018 was also reviewed, although evaluation of the delivered and received curriculum was not possible in this instance.

3.3.4 Focus group discussion

In continuing to address the research question 3, 'What are suggested curriculum content of CDDB in undergraduate nursing programmes in Indonesia?', this stage of study further aimed to identify elements that should be added to the curriculum framework. Instead of analysing the curriculum documents, involving key stakeholders

to gain feedback and comments about what has been included and dismissed in the existing curriculum is necessary (Kern et al., 2009). Within a pragmatist study, involving relevant experts who have specific experiences or knowledge of problems, can help define and address a problematic situation (Feinberg, 2012, p.5). Accordingly, a two-hours focus groups was held by the researcher to discuss this issue from the perspectives of an expert group of practitioner nurses, nurse educators, palliative care practitioners, professional nursing organisations and graduate alumni. Findings from the above faculty curriculum mapping were compared and contrasted with the findings identified in the focus group discussion, in order to determine suggested curriculum content.

3.3.5 Participant recruitment and data collection

I contacted the gatekeepers to inform them about the study. Four strategies were used to recruit the participants. First, through posters and flysheets attached to the notice boards located on three different campuses and teaching hospital. Second, I conducted five presentations in October and November 2016 to different groups of students, teaching staff and clinical instructors. Third, the gatekeepers approached the participants and distributed an invitation letter, including a participant information sheet with a reply slip. Fourth, social media features such as Facebook and Twitter were used to inform the potential participants. Social media offers a convenient, robust, and low-cost facility to spread information requiring prompt responses (Harris et al., 2015).

A purposeful (i.e. non-random) sampling strategy was further used to recruit participants who met the inclusion criteria, as described in Table 6. Purposive, judgemental, or theoretical sampling was chosen, whereby participants were selected on the basis of their prior knowledge or experience relating to the topics of study (Sandlowski, 2010; Polit and Beck, 2012).

Participants were first selected who were willing to share their views, and who held suitable positions and experience. All selected participants were either directly or indirectly involved in CDDB and clinical supervision, and had extensive experience in training development, monitoring, organisation and management. Overall, 30 participants (13 students, 12 teaching staff, and 5 clinical instructors) were recruited to the interview study and 8 key participants recruited to the focus group discussion. The sample size was chosen based on the needs of the study and the availability of local resources. Selected participants represented three different provinces: District of Jakarta, West Java and Central Java.

Table 6 Inclusion criteria for participants in this study

Participant	Inclusion criteria	Exclusion criteria
Nursing student of the interview group	Students enrolled in third, fourth (semester 5 or 6; 7 or 8) and fifth year of study (internship programme in semester 9 or 10) during pre-registration programme.	A third-year student who did not register in CCSA I (early clinical exposure programme)
Nurse educators of the interview group	• Full-time and tenured staff. • Practitioner nurses who are officially employed by the faculty as part-time clinical/community instructors. • Have at least one year of teaching and doing clinical supervision. • Have been involved in activities relating to curriculum development • Have a background in palliative care training or related course.	Nurse educators not on duty while the study fieldwork was undertaken.
Key participants of focus group discussion	• Representatives of institutions either in education or practice area relate to palliative care or healthcare services. • Have at least one year of working experience in the invited institutions.	Participants not eligible to be recruited as key participants.

3.4 Data analysis and interpretation

In qualitative research, data collection and analysis often takes place via an iterative and incremental process, which can move forwards and backwards at any stage (Miles and Huberman, 1994; Saldanha et al., 2013). This process facilitates 'data immersion', in which deep familiarity with the data and detection of elusive meanings is attained via a prolonged period of research activity (Sandelowski, 2010). This was the approach adopted in this study, allowing new insights to be gained as a result of ongoing critical appraisal of the data (Maykut, 1994; Fram, 2013).

Descriptive and interpretive thematic analysis of the data obtained from interviews, document reviews and focus group discussions (Miles and Huberman, 1994; Bender, 2011; Van Zyl, 2019) was carried out in order to identify patterns of meaning across the dataset. Data analysis was conducted following Carney's Ladder of Analytical Abstraction (1990, in Miles & Huberman, 1994, p. 92), which assists researchers in combining and integrating data obtained from various sources and through various methods (Van Zyl, 2019). There are five levels of data analysis following the ladder as depicted in figure 6 and thus explained in the following sections.

As a form of qualitative study, a grounded theory requires the researcher to select a priori theoretical framework to generate new theory from data (Charmaz, 2000). However, Sandelowski (1993) argues theory can also enter a qualitative study from the outsides. The presentation of theory thus provides a context or interpretive framework

to organise, analyse, and interpret the study findings (Bender, 2011, p.61). Constant comparison data analysis drawn from grounded theory methodology was applied to examine the relationships between key themes and concepts (Charmaz, 2000; Bender, 2011). Such method was further utilised to identify pattern differences and similarities among datasets (Fram, 2013).

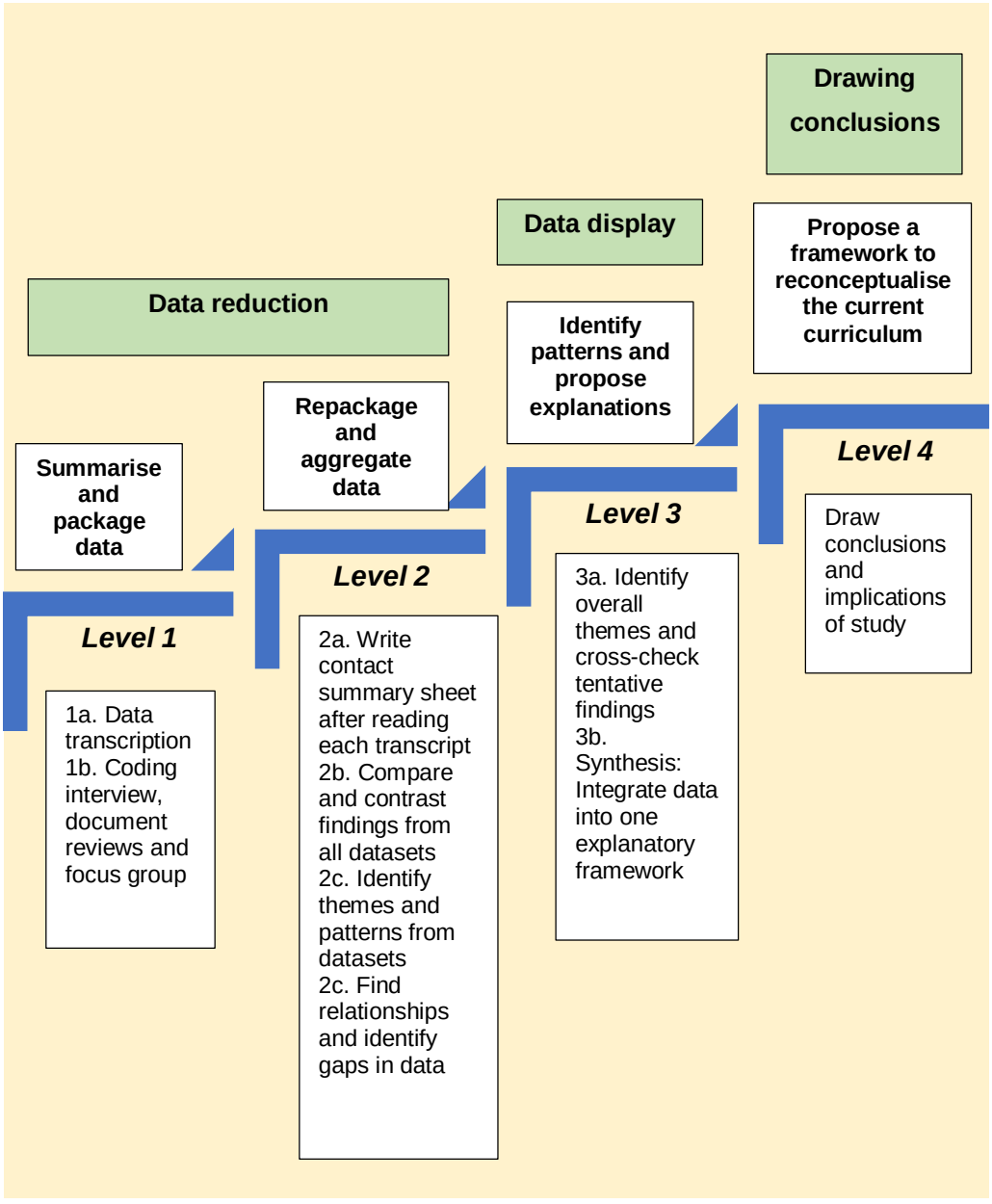

Figure 6 The analytical abstraction ladder used

(adapted from Miles and Huberman 1994; Bender, 2011; Fram, 2013; Van Zyl, 2019)

3.4.1 Level 1: Summarise and package data

I conducted audio-recorded all interviews and focus group conversations, and then transcribed verbatim these recordings within four hours of each interview. Transcripts

were checked and, where necessary, edited by listening to the audio recordings alongside reading the transcriptions. I then translated the transcripts into English prior to data analysis. This in-depth process facilitated data immersion, allowing codes and emergent themes to be identified in subsequent analysis (Watts, 2014).

In order to enhance the face validity of the content, the transcripts were emailed to all participants, who were asked to verify the issues that had been identified. All participants returned the files by email, including some minor feedback regarding misspellings, inappropriate abbreviations and unclear terms.

Identification of patterns in the data took place via a rigorous process of data familiarisation, coding, thematic development and revision. Margin notes were used as a coding aid in this analysis. Data codes (nodes) were created by the researcher following key phrases identified in the data, and these were then grouped into categories. Further grouping into subcategories was carried out and, through this process, overarching themes emerged (Miles and Huberman, 1994). All identified themes were compared and contrasted across all datasets (Fram, 2013).

From the curriculum mapping data, thematic content analysis was used to describe the results of the review process and to cluster the specific information (Wachtler et al., 2003; Pereira et al., 2015). Curriculum content was compared and contrasted with national (intended), institutional (planned) and delivered (received) curricula to identify any gaps (Kern et al., 2009). Evaluated components included core competencies, learning outcomes, teaching and learning content, methods of delivery and assessment, and typical learning outcomes (Harden, 2001). Those data were further compared and contrasted with findings obtained from the focus group. All themes, categories, sub-categories, and content identified during the data analysis were managed using NVIVO version 11.

3.4.2 Level 2: Repackage and aggregate the data

The data from level one were repackaged and aggregated. The emergent themes in the data were adopted as a framework to interpret and discuss all datasets (Van Zyl, 2019). As above, data were grouped based on sub-categories which had inductively emerged from the data categories (Archer, 2016 cited in van Zyl, 2019). Findings from all datasets were further compared and contrasted. Further description of this process is presented in Chapters 5 and 6. Table 7 below provides a limited selection of categories and codes developed to create a coding framework which guided the analysis of all datasets.

Table 7 Sample of selection of codes developed from the datasets

Content	Context	Outcomes	Pedagogy
Evidence-based practice	Classroom	Knowledge	Didactic teaching
Communication	Laboratory practice	Attitudes	Experiential learing
Ethics and values	Clinical practice	Skills	Problem-based learning
Cultural and spiritual	Community practice	Behaviours	Small group discussion

3.4.3 Level 3: Identify patterns and propose explanations

Findings from the previous stages (1 to 3) were critically analysed using sociocultural and transformative based learning principles. In the first step of data analysis, categories and sub-categories were cross-checked to ensure data accuracy, identify overlapping data, and condense data to analyse patterns and themes (Miles and Huberman, 1994). In the second step, categories and themes that developed from analysis of the scoping reviews, interviews, document analysis and focus group discussion were used to generate the final themes. Finally, further abstraction and conceptualisation was undertaken, with the aim of addressing research question 4: "How is curriculum content best structured and delivered within undergraduate nursing curricula to support the provision of CDDB in Indonesia?"

The results of all phases of the study were combined to construct an overall curriculum framework to promote care of the dying, dead and bereaved. Further description of this process is presented in Chapter 7.

3.4.4 Level 4: Propose a framework to reconceptualise the current curriculum

In this level, a framework was proposed to reconceptualise the existing curriculum relating to CDDB in undergraduate nursing programmes. The aim was to develop a purely conceptual framework, with an actual curriculum design being generated only once the structure had been reviewed and refined at institutional and national levels. Within a pragmatic approach, multiple theoretical lens were utilised to guide the operationalisaton of the framework developed following the analysis from level 1, 2 and 3 (Chapter 7). Theories are used to frame and represent the data only after a descriptive account of findings had been identified (Bender, 2011). Thus, theoretical rendering of findings of this study represents the secondary analysis of obtained data (p.61).

3.5 Rigour

In order to maintain the rigour of this study, attention was paid to the credibility, dependability, conformability and transferability of the methods and findings.

3.5.1 Credibility

Credibility refers to confidence in the truth of data, and is also defined as an alternative to internal validity. The goal of credibility is to determine whether research participants are accurately identified and described (Shenton, 2004). Polit and Beck (2012) state that prolonged engagement, persistent observations, external checks, member checking, researcher credibility and data triangulation are all measures which enhance the likelihood of producing credible results.

In this study, I spent sufficient time with participants in order to learn about their situations, build rapport and establish trusting relationships. Participants' comments were presented verbatim, in order to ensure their credibility (Lincoln and Guba, 1985), and in one instance I returned to the interviewee to verify whether the information they had provided had been understood correctly. Peer checking took place, involving sending the transcripts to a colleague (another qualitative PhD researcher) for checking in order to minimise personal bias. Documents were also sent to the supervisory team in order to identify any discrepancies regarding coding, categories and themes. Any disagreements were resolved via further analysis and discussion until agreement was reached.

In order to ensure accurate interpretation (trustworthiness or 'truth value' (Lincoln and Guba, 1985; Jeanfreau et al., 2010, p. 6), of the study findings, participants were invited to offer their opinions regarding the essential curriculum components required for CDDB in their learning environment or working situation. I made field notes to record my ideas, feelings and reactions during interactions with the participants, and these were written up as soon as each interview had finished. A contact summary sheet was also used which included my thoughts and associations with what was observed in each interview.

3.5.2 Dependability

Dependability refers to the reliability of a study, and involves consideration of the dynamic nature of the phenomenon under study (Fram, 2013). Thus, the dependability of data refers to the stability of such data over time and conditions (Polit and Beck, 2012).

A detailed audit trail, detailing the ways in which data were obtained and analysed and themes generated (Lincoln and Guba, 1985), was completed in order to provide transparency. All participants had confirmed their willingness to participate in the study by signing a consent form before their interview or focus group commenced. It was emphasized to participants that they were considered to be the experts in their field,

and that their opinions were valued and no ‘right’ or ‘wrong’ answers could be given. I conducted all interviews, and the suitability of the interviewing technique was established beforehand by conducting a pilot study and holding discussions with supervisors.

3.5.3 Confirmability

Confirmability refers to the objectivity of data (Sandelowski, 2010). The qualitative researcher needs to ensure that their findings arise from the data, and support any conclusion and recommendations, and that internal agreement is established between the researcher's interpretations and the actual evidence obtained. According to Lincoln and Guba (1985), confirmability reflects the criterion of neutrality, whereby researcher bias must be avoided in conducting research and analysing the findings. Confirmability may be obtained through a process of triangulation of data sources, thereby supporting or challenging the study findings via cross-reference to published literature.

In this study, the content of the individual interviews, focus group discussions and document reviews were made available for auditing (while ensuring anonymity of participants), including raw data, field notes and all analysed materials. A reflexive diary was used (following Norlyk and Harder, 2011) in order to facilitate the process of internal dialogue in analysing and understanding the research findings. Regular debriefing sessions were also held with the supervisory team to identify any potential flaws in the study and propose possible solutions (Shenton, 2004).

3.5.4 Transferability

In order to give full information to readers, it is necessary to provide ‘thick descriptions’ of the research setting, participants, and observed transactions and processes (Lincoln and Guba, 1985). Such descriptions may then be used by other researchers to judge whether to conduct a similar study in a similar context.

The transferability of this study was facilitated by providing a detailed description of the research design and methods used. The purposive sample selected in this study was defined by specifying clear inclusion criteria. The study findings were clearly illustrated using anonymised quotations (Polit and Beck, 2012).

The findings are expected to act in future as a reference for national accreditation boards and nursing organisations to evaluate and modify undergraduate nursing competency, curriculum and educational policies relevant to the provision of CDDB in Indonesia.

3.5.5 Triangulation

Data triangulation enables the comparison and convergence of study findings. Triangulation adds strength to findings, which are interwoven to illuminate a better understanding of the phenomenon and thus maintain the rigour of the study (Patton,

2015). Stakes (1995) proposes four strategies for triangulation: data source triangulation, investigator triangulation, theory triangulation and methodological triangulation. Multiple methods of triangulation were used in this study, involving utilising document reviews, interviews and focus group discussion.

3.6 Ethical considerations

3.6.1 Ethical Approval

Permission to conduct this research was obtained from the University of Nottingham's Faculty of Medicine and Health Sciences Ethics Committee, and from the Health Research Ethics Committee of the Medical School of Universitas Padjadjaran.

A participant information sheet was provided to all participants prior to data collection, detailing the aims of the study, the processes involved, and the participant's role in the research. The advantages and disadvantages of participation, and the option to withdraw from the study, were all clarified.

For interview and focus group participants, a formal invitation signed by the dean of FoN Unpad was sent to the heads of the institutions in which the targeted experts or practitioners were employed, together with an approval letter from the institutions named above and the participant information sheet. Only those participants who had obtained written permission from their institution participated in the focus group.

Nurses and other relevant practitioners were invited to participate to discuss their points of view on the curriculum components considered essential for CDDB. All prospective participants were asked to sign a consent form and were given a duplicate copy of this form upon completion.

3.6.2 Ethical principles

Ethical considerations are a fundamentally important aspect of research, particularly in health sciences. First and foremost, the researcher must respect the rights, needs, values and wishes of participants (Creswell, 2013). Therefore, ethical principles were fully adhered to, as described in Table 8.

Table 8 Ethical principles addressed in this study

Ethical principles	How addresses in this study
Informed consent	The principal researcher translated the consent form, information sheets, flyers, posters, and interview guidelines into the local language (Bahasa Indonesia) to be understood by participants. The principal researcher provided a direct explanation of the study either via face-to-face discussion or electronic messages (email, SMS, or messenger services).
Beneficence	The benefit of research is long-term and aims to improve the quality of CDDB in Indonesia.
Confidentiality	The information gained from participants in the interview study and focus group discussions were anonymised and kept confidential.
Justice	All participants who meet the inclusion criteria have a similar opportunity to participate in the study and received fair information about the study.
Non-maleficence	The researcher tried to reduce the potential for anxiety and stress through the provision of information about the nature of the study, as well as by adopting a flexible interview style and signposting to support services if the participant became distressed.
Self-determination	Participation was entirely voluntary, and participants had the right to participate or withdraw from this study at any time without justification.

3.6.3 Protecting participants from harm

In taking part in interviews about CDDB, it is possible that students or nurse educators may have found it difficult to cope with the sensitive nature of the issue (Houghton et al., 2010). In this study, participants were given the option of referral to counselling services if any issues arose which they wished to discuss further.

An ‘on-off’ interview process was also offered in case participants became distressed or had difficulty expressing their thoughts or emotions. To ensure that my own emotional health was maintained, monthly supervision and debriefing meetings were carried out with academic supervisors via Skype, and counselling was offered via the teaching hospital or Universitas Padjadjaran if needed.

3.6.4 Relationships and anonymity

In the initial stages of the research, I aimed to build rapport with the participants. The relationships between participants and I were maintained over the study duration, whilst I also anticipating possible challenges regarding the limitations and eventual termination of these relationships. Participants were assured that participation in the study would not impact on their activities or performance as students or members of staff. Participants were further assured that their names and personal details would remain confidential and anonymous in reporting the results of the research. All audio-recordings

were stored in password-protected personal computer files, and I was the only person who could access or edit these files.

In summary, the following safeguards were put in place:

- The research objectives were expressed both verbally and in writing so that participants could clearly understand them.
- A formal invitation and consent form were emailed to all invited participants before the first meeting.
- The participants were informed of all data collection procedures and activities.
- Written interpretations and reports were made available to the participants.
- The participants' rights, interests and wishes were considered in all stages of data gathering, handling, reporting and dissemination procedures.

Team members from different faculty units, who were not involved in clinical learning supervision, assisted with the administrative aspects of the study. This helped in navigating any potential power relation issues that might have arisen due to me occupying a dual role as lecturer-researcher and researcher-colleague.

3.6.5 Researching in the researcher's own institution

I did encounter potential power issues relating to interviewing stakeholders who held positions of greater seniority (e.g. heads of departments, senior academics), interviewing peers (academics, nurse practitioners, physician colleagues), and interviewing those who were indirect subordinates (students and junior lecturers). There were also potential issues relating to anonymity and confidentiality in such a small community. Particular attention was therefore paid to ensuring that all such participants were ethically protected (see section 3.9.3).

3.7 Conclusion

It is important that researchers provide an anticipative, reflexive, and self-critical approach in designing, conducting, and writing up their research (Finlay, 2002). In this chapter, the pragmatic approach to the research was presented, applying the first two steps of the modified Kern's six-step approach (Kern et al., 1994; van Zyl, 2019) as the process model.

The following chapters present the scoping review of educational curricula in Asia, a description of the semi structured interviews carried out with students and nurse educators, and the curriculum mapping exercise carried out in a nursing faculty.

4 Mapping the Content of Asian Nursing Curriculum

4.1 4.1 Introduction

A literature review was previously undertaken (see chapter 2) to identify what was already known about CBBD in international nursing education and practice. Findings revealed that information relating to CDDB focuses on the attributes and scope of practice, impact of dying and death exposures among students and nurses, factors influencing practice, CDDB implementation in nursing practice and academia, and identified gaps. Whilst several publications have suggested suitable content for inclusion in the undergraduate nursing curriculum, none have provided comprehensive or conclusive recommendations for the construction of a curriculum framework. Furthermore, few studies have focused specifically on the implementation of CDDB education in resource-limited settings (Bassah et al., 2014; van der Wrath et al., 2015) and in Asia (Mok et al., 2002; Jo et al., 2015).

This stage of the research addressed research question 1: “How is CDDB included and implemented in undergraduate nursing programmes in Asian settings?”. This chapter presents the findings of a scoping review of Asian undergraduate nursing curricula. The aim was to map the curriculum content and pedagogical strategies used to teach about CDDB in Asian universities, and thus to verify the CDDB-related content and pedagogy that could be included in undergraduate nursing programmes in Asian nursing education.

4.2 Methods

As a part of stage 1 of the study, a scoping review of global literature was conducted (Chapter 2), followed by a curriculum document review of Asian undergraduate nursing. This study was in line with Kern’s first step in curriculum development, which identifies the problem and performs a general needs assessment by exploring the differences between ideal and actual practice (Kern et al., 2009). Kern et al. further explains that reviewing relevant documentation and interviewing multiple stakeholders and users can illuminate current teaching and learning approaches. A document review process was further conducted following a scoping review approach (Arksey and O’Malley, 2005).

4.2.1 Inclusion/exclusion criteria

Prior to documentation review, preliminary questions were developed: 1) what is already known about the care of the dying, dead and bereaved in the context of Asian undergraduate nursing education and 2) how curriculum content is delivered and evaluated in the undergraduate nursing programme.

The inclusion and exclusion criteria for the scoping review are detailed in Table 9. Both published and (where necessary) unpublished educational materials were eligible for

inclusion, including curricula, syllabuses, course guidelines, learning objectives, core competencies, teaching materials and related manuscripts and policy papers.

The scoping review focused on materials relating to nursing education only in Asian countries (Eastern Asia, Western Asia, South-central Asia and South-Eastern Asia, according to the UN categorisation (United Nations, 2014)). The review was restricted to English publications, plus abstracts or executive summaries that had been written in English of studies originally written in other languages.

Table 9 Inclusion and exclusion criteria

Inclusion	Exclusion
Published/ created between 2000-2015	Unable to source document due to the document not being freely available online and: No contact details are given The contact did not respond or declined to provide required materials Not available through the University of Nottingham library services.
Focuses on end-of-life/ palliative care education	No abstract, summary or document written in English
Institutions located in Asian countries	Non-Asian Universities or organisations
It is focussed on any aspect of curriculum development for undergraduate and pre-registration nursing students	Did not include part of curricular components

4.2.2 Data selection

The electronic databases searched were CINAHL, EMBASE, Medline, PsycINFO, EMBASE, ASSIA and Web of Sciences. Google and Google Scholar were also used to search the literature. The search terms used were as shown in Table 10.

Table 10 Key search terms used in electronic databases

Concept	Search term
Care	Palliative care, end of life care, terminal care, hospice care, bereavement care
Dying, dead and bereaved	Dying, death, grief, bereave*
Curriculum	Curricul*, syllabus, guideline, competence*, learning outcome*
Nursing education	Teaching, classroom-based, clinical teaching, training
Undergraduate	Bachelor degree, pre-registration, pre-licensure, pre-certification
Asia	Asian, Asia, developing countries, high-income countries, low-income countries, limited-resource setting, resource-poor countries

The Webometrics world ranking system was also used to identify the top ten universities in each Asian country (Jalal et al., 2016). I also searched professional organisation

websites that provide information about dying and death education for health professionals and students. The websites of each of these universities or organisations were then searched for relevant open-access documents. Since documents were identified on an open-access basis, it was not necessary to obtain ethical approval to access any materials (Pereira et al., 2015). Where necessary, authors or other contacts in the identified institutions were contacted by email to request unpublished curriculum documents or to obtain further information on curriculum implementation. In the case of insufficient information or restricted access, a 'snowballing' strategy was used to identify other organisations or contacts for further correspondence (Pesut et al., 2018). The snowball technique was also employed to identify relevant studies from database searches, and to locate additional documents by examining reference lists, authors' affiliations, and other open sources.

PRISMA flowchart of the search strategy used is shown in Figure 7 below.

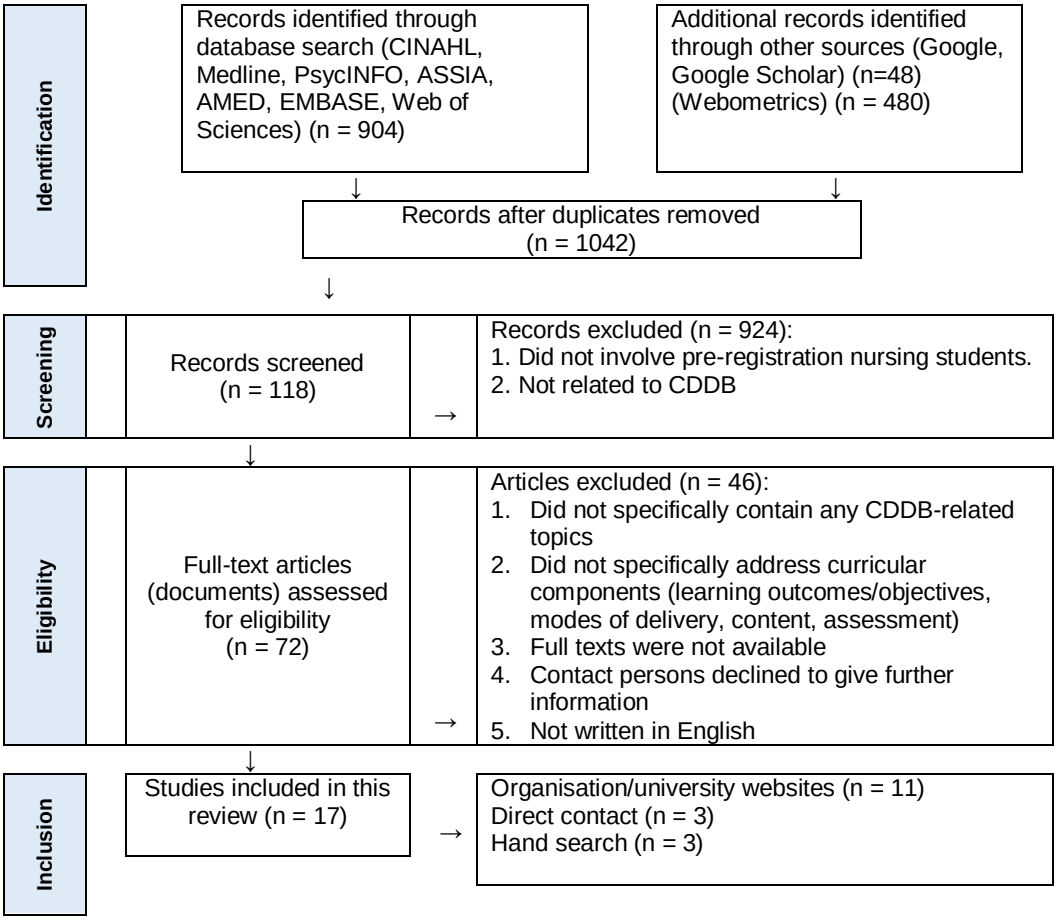

Figure 7 PRISMA search strategy

4.2.3 Data analysis

In this mapping study, curricular documents were analysed using content analysis (Bender, 2011; Rohwer et al., 2015) to examine components relating to CDDB. Content analysis is a pragmatic method for collecting and analysing textual data from various

sources, which is both flexible and systematic (Bender, 2011). For the document review, a set of codes was developed based on the previous scoping review results (see section 2.4.4.1). Codes were identified for each of the following categories: outcomes area (with sub-codes for each enabling competency), objectives (sub-codes for learning domains such as cognitive, affective or psychomotor), methods of delivery (sub-codes for didactic teaching, group tutorials, online learning, independent learning, laboratory or clinical practice), and assessment (written test, assignment, practical assessment, online test, and others).

4.3 Results

Curricula were identified from countries in East Asia (n=10), South Asia (n=6) and South-East Asia (n=1). Three major themes emerged: outcomes and objectives, pedagogical approach, and curriculum support.

4.3.1 Outcomes and objectives

Only eleven of the reviewed curricula were found to contain specific learning outcomes or objectives. Half of these mentioned specific competencies related to CDDB, whereas others presented only their learning objectives.

Enabling competency is a sub-set of competencies that are needed to achieve the key competency (Rohwer et al., 2015). Seven themes were identified relating to key competency and enabling competency (i.e. learning outcomes): 1) knowledge for practice, 2) ethical and legal considerations, 3) communication and interpersonal skills, 4) clinical practice skills, 5) psychosocial, cultural and spiritual care, 6) care after death, and 7) personal and professional development. These are detailed in Table 11.

The seven domains of key competencies show similarities with the ELNEC core curriculum - an international framework of EoLCE applied in more than 70 countries worldwide (Ferrell et al., 2015) as discussed in chapter 2 (see section 2.3.4.3).

Some of the above topics were integrated into existing curricula (n=9), whereas others were provided as discrete subjects (n=8). The East-Asian universities (Korea, Japan, Taiwan and Hong Kong) seemed to offer more discrete (single-subject) and elective (non-complusory) subjects than others. These subjects were predominantly allocated to second or third year students, and none were provided for fourth or fifth years. However, actual delivered and taught content were not evaluated since this was beyond the scope of the study.

Table 11. Identified content in reviewed curricula

Key competency	*Enabling competency*	*Description of content*	*Domain of learning*
Knowledge for practice	Knowledge about palliative care and EoLC	Pathophysiology of dying and death Definition of palliative and EoLC History and philosophy of palliative care Healthcare policy relevant to palliative and EoLC Loss, grief, and bereavement theory	Cognitive
	Philosophy of dying and death	The concept of death and dying The meaning of life and death	
Ethical and legal considerations	Moral, ethics and legal aspects related to palliative and EoLC	The supportive understanding environment at the end of life Ethics and legal issues in caring the dying and dead patients Advance directives Decision making at the end of life	Affective
Communication and interpersonal skills	Effective communication with dying patients, family, and other health professionals.	Therapeutic communication Breaking bad news Interprofessional collaboration	Psychomotor
Clinical practice skills	Care of the imminently dying	End of life assessment Primary nursing care for managing symptoms and giving comforts Care coordination Assisting the dying patient Transition of care Patient-and-family centred care	Psychomotor
Psychosocial, cultural and spiritual care	Psychosocial, cultural and spiritual issues of patients and families	Attitudes towards dying and death Values, belief, and norms related to dying and death Identifying burdens of family caregivers	Affective
Care after death	Care of the deceased body	Caring for the deceased body Declaration of death Transfer the dead body Funerals	Psychomotor
	Caring the bereaved family	Assisting the bereaved Performing counselling	Psychomotor
Personal and professional development	Recognising self and others	Knowing self and others Critical thinking and life-long learning Maintaining self-care capacity	Affective
	Professional accountability	Roles and responsibilities of nurses in CDDB	Cognitive

4.3.2 Pedagogical approach

The concept of pedagogy and practice emerged from findings which indicated learning context, teaching and learning methodologies and assessment methods.

Topics relating to EoLC were offered to undergraduate students within different phases of their nursing studies. Most of this content was delivered in classroom settings within the second (and sometimes third) year of study. Few of the institutional curriculum included clinical learning settings as part of the teaching and learning process.

Eleven of the curricular documents described the instructional methods or pedagogical strategies used (see table 12). The academic approach was the most common method for educating undergraduate nursing students about CDDB, followed by active learning. The majority of the curricula used lecture formats, combined with group discussions and role play. Few institutions apparently used experiential and simulated learning and clinical practice as part of their teaching and learning methods (Kaoshiung Medical University, 2015; Higher Education Commission Islamabad, 2011; Kiang Wu Nursing College, 2016; The Tamil Nadu Medical University, 2010; Kerala University School of Health Sciences, 2010).

Table 12 Context and pedagogy practice identified through reviewed curricula

Content	Methods of delivery
Didactic teaching	Lectures, workshops, seminars.
Active learning	Small group discussion, case-based learning, problem-based learning, project-based learning, blended learning, online learning, games, group presentation
Experiential learning	Storytelling, simulated learning, role plays, films, artwork projects, reflective practices, clinical practices/clinical visits.

There were wide variations in the teaching time allocated to CBBD-related subjects, and few of the studied curricula provided standardised teaching hours to deliver EoLCE. Teaching time ranged from 1 to 100 hours of instruction, and covered periods ranging from one day to several semesters, over the course of the three to four years of education. In most schools in South and South-East Asia, a single face-to-face meeting which is delivered for one hour per session was provided.

The reviewed curricula utilised Bloom's taxonomy of learning to develop learning objectives, clustered into three categories: cognitive, affective and psychomotor. This taxonomy was also used in EAPC and AACN's curricular guidelines of palliative care education for pre-registration nursing programmes. Furthermore, the majority of educators used self-report instruments, focussing on students' evaluations of their knowledge, attitudes and perceived competence, to evaluate teaching and learning (Jo et al., 2015; Jo et al., 2009; Divyalasya et al., 2014; Kim et al., 2015; Moon et al., 2015; Wong, 2015; Hwang et al., 2005). Only two studies combined such self-report instruments with qualitative interviews (Takenouchi et al., 2011; Hwang et al., 2005). Other scholars used qualitative interpretive methods to evaluate students' reflective

journals (Wong et al., 2001; Liu et al., 2011). Further description of the association between domains of learning and methods of assessment is shown in Table 13 below.

Table 13 Domains of learning and associated assessment methods

Domain of learning	Methods
Cognitive	Written exams, individual essay/paper, self-reported test, group presentations
Affective	Reflective practice/journal, feedback worksheets, self-attendance
Psychomotor	Skills assessment

4.3.3 Curriculum support

Little information was found about support given by national or regional government and organisations in relation to the inclusion of CDDB into undergraduate nursing curricula. In India, the majority of nursing schools showed similar content with those generated by WHO Trivandrum (2013) to guide palliative care education. No empirical studies reported the process of incorporating these contents into the intended curriculum. Findings showed that contextual factors, as embedded in the majority of East Asian and South Asian curricula, focused on cultural and spiritual views of dying, death and bereavement and its relevant interventions (Jo et al., 2015; WHO Trivandrum, 2013). No consensus was identified about the standards of curriculum guidelines in CDDB for nursing students. In general, the availability of national guidelines can support the development of palliative care education and thus can guide universities in standardising the curriculum content. Further attention should be paid towards multifaceted contextual factors that cover social, cultural, political, economic and environmental dimensions.

4.4 Discussion

In this scoping review, Step 1 of Kern's six-step approach to curriculum design was used to guide the evaluation of the content of the Asian nursing curriculum. The curriculum mapping process assisted in identifying potential CDDB activities and suitable groupings for such teaching and learning activities. Specifically, a scoping review of Asian curricula has been highlighted, due to Asian countries' similarities with Indonesia in terms of social, economic, political, and cultural situations that inform the curriculum development process.

Recent reviews indicate a lack of content-related research and evidence-based practice in EoLC and CDDB, and a lack of information concerning curriculum development in EoLCE. The purpose of this phase of the study was to undertake a review of currently-

available curricula in order to support the development of a programme of CDDB education for undergraduate student nurses in Asia. Kern's six-step approach of curriculum design was used as a framework to guide a systematic approach to identifying themes and activities that lend themselves to EoLCE.

A wide range of curriculum learning outcomes were identified from the included curriculum documents, and these were grouped into seven broad themes. Several of these themes (see section 4.3.1) reflect areas that are integral to an end of life care approach and practice. Other themes, such as professional relationships and personal and professional development, may be considered more related to general aspects of nursing competency. Some of the themes and subthemes identified are less well accommodated in some of the international core competencies (as discussed in chapter 2), for example, knowledge for practice, which incorporates philosophy and meaning of dying and death, and cultural and spiritual care in CDDB.

Findings revealed an integrated approach is more often utilised to teaching care of the dying, dead and bereaved than delivered as a discrete or elective subject. Basically, the choice of either a stand-alone or an integrated subject must be decided after assessing the institution's needs. Nevertheless, international reviewed studies identified the great variance of teaching content related to PEOLC (Pesut et al., 2014; Lippe et al., 2015). Moreover, the presentation of topics relevant to dying and death is often underestimated. Yet, palliative care is often regarded as an 'orphan subject' with no specific unit or department to be integrated into (Pereira et al., 2016), while EoLC is considered a 'hidden subject' (Johnson, 2011; Condon et al., 2014) in the general curriculum. This condition can make the topics about dying, death and bereavement will remain invisible, otherwise any improvement could be made. If national curriculum guidelines about EoLC are established, then local institutions need to conduct periodic curriculum-mapping activities (Rohwer et al., 2015). This will identify, and overcome any, overlapping or missing topics (Kern et al., 2009) and thus highlight the best solution to counter problems.

The findings are further in line with international studies that indicate that most nursing curricula have focused on classroom activities, with an emphasis on cognitive and sometimes affective learning, rather than on clinical exposures and other real-life experiences (Wilson et al., 2011; Cavaye et al., 2014; Lippe et al., 2015). Researchers agree that experiential learning is essential in helping students to gain the knowledge, skills and attitudes necessary to provide EoLC and to be comfortable in providing CDDB (Mallory, 2003; Kavanaugh et al., 2009; van der Wrath et al., 2015). Curriculum developers therefore need to be more creative in expanding clinical practice opportunities beyond overburdened curricula and heavy reliance on hospital-based learning settings (Wilson et al., 2011).

Four critical issues were revealed, based on review findings of the Asian undergraduate and pre-registration nursing curricula around CDDB. Firstly, the majority of curricula come from high-income countries in Asia, which present different situations and contextual factors (i.e. social, economics, politics, and environment) with those from low-income countries. Curriculum influenced by multidimensional aspects situated in one country that should be paid attention by policy makers and curriculum developers (UNESCO, 2012; Ornstein et al., 2017). Secondly, unclear core competencies delineated the learning outcomes and objectives used in the learning guides. Neglected topics in relation to learning outcomes and objectives included leadership, research and evidence-based practice, and community empowerment. Thirdly, CDDB topics were not extensively covered in the curricula studied. As a result, the integration of topics with other courses could not be explored, and overlapping topics were difficult to identify. Fourthly, the utilisation of educational strategies varied depending on the institution and country being studied. Finally, in terms of pedagogy practice, a combination of didactic teaching and active learning strategies was the most common approach. Experiential learning and simulation-based learning were under-used, despite their popularity in current global nursing education (Grubb et al., 2016). None of the studied works mentioned evidence-based curricula and the development of such curricula relative to stakeholders.

Across the 48 countries in Asia, nurses work in a variety of healthcare situations. Some may not have sufficient palliative and end of life care to relieve the sufferings of patients with advance progressive illnesses and their families, and some may feel powerless in the face of complex ethical issues. Regardless of social, cultural, political, economic and environmental differences, a nurse acts as a care provider and an advocate to the dying patient and their family. Nurses thus share a common mission to meet the patients' and family's needs, assess their functional capacities, and assist them in actualizing that potential through daily nursing practice in CDDB. As suggested by Takenouchi (2018), nurses in Asia are called upon to serve as their patients' advocates and to ensure that patients live with dignity until the end. Hence, having structured teaching and learning about CDDB is an urgent agenda in Asian nursing educational instutions.

Based on the findings, there is scant research based in Asian countries that focuses on a shared understanding of issues surrounding EoLC and CDDB. Research is thus needed to focus on developing and implementing EoLCE and CDDB for nurses within the context of Asia's unique cultural background (Takenouchi, 2018). The time has come for curriculum developers, educators and practitioners in Asian nursing to develop a curriculum framework of EoLCE and CDDB, and implement this into current academic programmes and practice. Problem identification and needs assessment in relation to CDDB should be explored within the current situation of nursing practice and education within each country in Asia. Kern et al. have further recommended exploring opinions

of students and teachers regarding recent curriculum implementation may help to identify grassroots problems.

4.5 Limitations

There were some limitations of this scoping review that should be acknowledged. The focus of this study was on curricula related to CDDB for undergraduate nursing students, and therefore other, potentially relevant, health professional curricula were not explored. In addition, the search strategy utilised included specific search terms, a limited selection of databases and online resources, and a relatively small overall number of reviewed publications and documents.

4.6 Implications of study

The curriculum mapping process allows the following: 1) Curriculum developers to consider designing CDDB opportunities for students and nurses, which can be mapped onto specific outcomes set by institutions; 2) New ideas for CDDB-related learning activities; 3) Administrators to initiate the exploration of the framework of the EoLCE and CDDB curriculum for undergraduate nursing students in other countries; 4) Validation of existing EoLCE programs against the regulatory standards of nursing education and practice; 5) Baseline findings for designing new CDDB initiatives, or for determining existing educational activities that could be applied or modified to support CDDB.

This study highlights the opportunity for curriculum developers and administrators to consider developing a curriculum framework for pre-registration CDDB. One of the main considerations for delivering CDDB is maintaining its relevance and meaning for all students, and establishing nationally-derived outcomes would help to achieve this. The amount of curriculum overlap and similarity of content in other international frameworks provides strong evidence for the potential to produce a set of core educational content for undergraduate CDDB, guided by regulatory requirements for Asian nursing graduates.

Further research about curriculum development is thus needed. In addition to clarifying the focus of CDDB for both educators and students, further development may assist by establishing the curriculum framework across institutions, helping to compare and contrast pre-clinical and clinical educational interventions, and assessing different methods of delivering CDDB. In addition, prior to designing specific teaching and learning programmes, conducting a needs assessment from the perspectives of students and nurse educators may help to identify barriers and enablers relating to CDDB in the learning environment.

4.7 Conclusion

There are no clear standards relating to how CDDB is included in the Asian nursing curriculum. However, the reviewed curricula do recognise the importance of dying, death and bereavement in undergraduate nursing education.

The scope of CDDB content is likely to increase in future, in line with the growing population and needs of EoLC in global settings. Future efforts should focus on improving pedagogy and teaching practice, and providing adequate support and facilication to enhance the availability and sustainability of CDDB in both pre-clinical and clinical learning environments.

The themes and subthemes identified in this review will be used to inform the subsequent stages of this research study. Stage two of the study (step 2 of Kern's model), as presented in the next chapter, focuses on exploring students' and nurse educators' perceptions, experiences and needs relating to CDDB in an undergraduate nursing programme.

5 Perceptions, Experiences and Needs relating to Care of the Dying, Dead and Bereaved in the Learning Environment

5.1 Introduction

This chapter describes the results of stage two of the study, which aimed to answer the research question: 'What are the perceptions, experiences and needs relating to CDDB in the learning environment?' This stage of the study explored the implications of developing an EoLCE framework and revealed insights into the factors influencing perceptions and attitudes towards death, dying and bereavement.

Qualitative data from the two groups were analysed separately to identify individual group patterns, and similarities and differences between the groups. Following descriptive and inductive thematic data analysis using Miles and Huberman's method and following Kern's model, as described in Chapter 3, emergent themes and sub themes were identified and explored.

The four major themes identified are described in Table 14 and discussed in sections 5.2 to 5.5 below.

Table 14 Themes and subthemes relating to students' and nurse educators' views on CDDB

Themes	Subthemes
5.2 Professional attributes and skills for practice	5.2.1 Knowledge and skills towards a meaningful practice 5.2.2 Cultural and spiritual based caring 5.2.3 Information and support provision 5.2.4 Standardised clinical practice
5.3 Barriers and challenges to establish professional relationship	5.3.1 Communication and relational issues 5.3.2 Adequate preparation and support 5.3.3 Student-teacher interaction 5.3.4 Reflection and engagement 5.3.5 Social learning environment
5.4 Needs of support and facilitation towards professional agency	5.4.1 Teaching and mentoring agency 5.4.2 Disorienting roles and responsibilities in clinical teaching 5.4.3 Personal and professional reflexivity 5.4.4 Clinical mentoring and supervision

	5.4.5 Limited resources and access provision
5.5 Negotiating curriculum content and pedagogy practice	5.5.1 Incongruent learning experiences 5.5.2 Needs for content negotiation 5.5.3 Transforming frame of references

5.2 Professional attributes and skills for practice

Professional attributes and skills for practice relates to the capacity to conduct practice according to the roles and responsibilities of nurses within healthcare settings. Interview participants were encouraged to discuss their perceptions, experiences and needs when caring for people at the end of life. Participants also discussed what makes an ideal practice of CDDB, and identified the differences between ideal practice and actual current practice, as proposed in Kern's model step 1 (Kern et al., 2009).

Overall, participants emphasised the importance of nurses being competent to provide CDDB, whether in clinical or community settings. Participants shared their understandings about the antecedents of CDDB, emphasising the acquisition of knowledge, attitudes, skills and values. Further analysis of the data revealed four essential elements which support professional attributes and skills for practice in CDDB: knowledge and skills for practice, cultural and spiritual-based caring, information and support provision, and standardised clinical practice.

5.2.1 Knowledge and skills towards a meaningful practice

Interview participants indicated that inadequate knowledge and skills contributed to their paying less attention to CDDB. Moreover, much of the participants' experiences of CDDB reflected a lack of empirical knowledge and a reliance on personal knowledge to guide their clinical practice. Faculty staff and clinical instructors reported following traditional practices and employing tacit knowledge to recognise patients' needs and provide care for dying patients and their families, particularly in non-ICU settings. For example, whilst the majority of participants referred to using physical indicators (vital signs and haemodynamic status), the more advanced nurses tended to use their intuition to recognise when death is approaching. This indicates an overall lack of knowledge about the trajectory of dying and death, a lack of ability to perform EoL assessments, and an absence of standardised practice guidance for students and nurses.

> *(...) I can sense the patient's aura when the patient is already dying. I know it is not scientific when you say you can feel it but perhaps I can read the facial expression and the way they communicate. (PCI-04)*

Participants experienced further significant difficulties in dealing with the complexities and uncertainties of the EoL stage. Only one clinical instructor with formal palliative care education was familiar with the use of EoL assessment tools. In line with the reports of

their clinical mentors, senior students also reported relying on their intuition and personal judgement to identify patients' current status and needs. Such learning methods represent a form of 'socialisation' learning activities, and are one of the major means of students learning about real-life clinical issues.

> *I think most of the patients who will die, they can't see us directly by looking through their eyes. It's just like 'empty looks' (…) (PS-06)*

Although participants had difficulty in assessing the dying state, they were in agreement that providing basic comfort care is the ultimate intervention given to patients. They described ideal concepts of CDDB as proposed by NICE (2015), focusing on reducing patients' suffering through providing comfort care, which includes personal hygiene, respiration, nutrition, hydration, elimination, and care of wounds and pressure ulcers. Participants were also aware of pain that might be experienced by patients at the EoL and recognised pain management as crucial for dying patients. However, most students and nurse educators had not had enough clinical learning opportunities to support such practice.

Most participants found it challenging to differentiate between palliative care and EoLC, despite having previously attended lectures or seminars related to the former. Palliative care was understood as caring for cancer patients in advanced (terminal) stages, or other incurable diseases entailing pain and symptom management. Moreoever, participants often associated comfort care with palliative care.

> *(…) palliative care is caring for the dying patient that could make them happy and comfortable (…)* (PS-07)

> *It is about providing analgesics for their pain, not for curing their disease (…)* (PS-10)

Where students and nurses had inadequate clinical knowledge and skills around caring for the dying, they tended to focus on other aspects, such as spiritual care, to reduce pain and other discomforts, and focused on caring for the dying patient based on their faith and religion. Participants viewed the centrality of palliative care services as being to meet patients' spiritual and religious needs. As an example of how spiritual care is embedded in CDDB, both students and nurses often reported reciting prayers and performing rituals based on their own faith and religion, to help reduce patients' physical and psychological discomforts.

> *(…) she said that it was so painful' (…) then I told her to say, "'Astagfirullah, mam...istigfar… istigfar" (recited prayers) instead of letting her cry out because of the pain (…)* (PS-07)

Several nurse educators were aware of the complications and dilemmas surrounding ethical and legal aspects at the end of life. They reported constraints in giving timely

clinical interventions and noticing patient suffering, and related this to several factors, including lack of information provided by health practitioners, family culture in decision-making, dominance of the medical profession, and lack of professional autonomy. Some students further reported feeling that patients and their families were being oppressed, yet perceived themselves as having a lack of power and professional competence to offer suitable advice and support. Such experiences were reported to have made students more prone to anxiety and distress.

Several participants reported a lack of clarity about their roles and responsibilities in relation to CDDB. This, along with inadequate clinical support, led to an oppressive learning environment in which students were prone towards exploitation. For example, ward nurses sometimes delegated aggressive treatment to students, resulting in feelings of powerlessness.

> *(…) I came to the ward in the morning, and the nurses said, 'this is a DNR patient! However, anyway, let us do the CPR!' (…) We should not do the CPR. It was a DNR status! We should be able to whisper to her ear "La ilaha ilallah…' (…) I do not know about this mam (…)* (PS-06)

An overall lack of power, and inadequate knowledge about ethical and legal aspects and advocacy, was revealed on the part of students, specifically with regard to contributing to the clinical decision-making processes. Failure to understand ethical and legal issues was reported to oppress students, and/or could made them 'oppressor agents' towards patients and their families, often leading to further confusion and potential moral distress in students.

Care after death was a significant issue for students. They reported feeling apprehensive about handling the dead body, and attributed this mainly to a lack of standards and procedures in their academic and clinical learning guidance. However, students agreed that maintaining dignity by giving respectful and humanistic care was important in handling the deceased body. Care after death activities were further understood as traditional activities, following a discernible routine, including assessing and monitoring the dead body, cleaning and wrapping, preparing for death reports, and transferring the dead body to the mortuary unit. Creating a suitable body appearance was seen as a central goal of caring for the dead body, with the aim of avoiding alarming the family or others. Such efforts reflect socially- and culturally-constructed practices surrounding maintaining dignity of the deceased body.

Overall, participants demonstrated an urgent need for knowledge and practical experience in caring for dying and deceased patients, including principles of palliative and end of life care, ethical and moral considerations, assessment, and practical nursing care. Findings further indicated that participants' knowledge and skills developed through a socialisation process during clinical practice, rather than having been obtained through academic preparation.

5.2.2 Cultural and spiritual based caring

Spiritual care was considered central to CDDB among both students and nurse educators, each of whom emphasised family involvement in care, and support for the values, religious beliefs and rituals of patients and families. Nurses were expected to possess skills related to both their own religion and to others', so that they would be able to provide spiritual care for dying patients whenever normal support for this was absent. (It should be noted here that all Indonesian citizens have an official religion). Most participants noted that it is common for nurses to suggest that families of dying patients recite prayers in the wards. On some occasions they reported that nurses called for the 'WAROIS' team (Muslim chaplains) to guide dying patients by reciting *Shahadah* (the Muslim declaration of faith).

In contrast, the role of chaplains at the end of life was less familiar among students, as reported by the following participant:

> *Usually, they did not do anything. They just often said "Do not forget to read Shahada, Sir" They reminded the patients, but to be honest, I do not understand what their duties are? (…)* (PS-11)

In a similar vein, clinical instructors agreed that their limitations in providing spiritual guidance often prevented them from meeting patients' spiritual needs, and led them to consult the spiritual care team in the hospital. In recognising spiritual needs, clinical instructors pointed out that nurses must have a basic understanding of how to provide spiritual guidance according to their own and the patient's religion. Such skills would enable them to support dying patients whenever families were absent or chaplains were unavailable in the hospital.

> *(…) We might find various rituals from diverse religious or racial background of the patients (…) it is essential for students to know whom to talk to or whom to consult with when they need to take care of a non-Muslim patient (…)* (PCI-01)

Clinical instructors confirmed that most healthcare practitioners do not talk about dying and death to family members, due to this being taboo, particularly when dying patients are in a delirious state or when they have witnessed other patients' deaths on the same ward. In such situations, family members often negotiated with nurses to move the patient away from such a 'threatening' place to a more 'neutral' one. As a result, nurses often felt they had to go along with service users' beliefs that death is contagious or a source of 'haunting'.

Student participants further reported that service users often exhibited 'folk beliefs' that stigmatised death as a source of bad luck for patients and their families. One student noted that a nurse preceptor decided to acquiesce in such beliefs without providing additional clinical information:

> *Hmm, they think that it was like a cycle, so they asked the nurses to move them to another room. Two patients died subsequently (…) when there was an unoccupied bed, the nurses helped them to move out. The nurses said 'well, it is all right since nobody will get the harmful effect' (…)* (PS-06)

As stated in the Introduction section, ninety percent of participants were Muslims, this representing the dominant religion among the study participants. The Muslim students reported having had learning opportunities regarding care of the dead body during their Islamic religion course, while others had gained knowledge of this topic through extracurricular programmes (Chapter 4). However, non-Muslim students had not learned such specific interventions, either in intracurricular or extracurricular programmes (FoN Unpad, 2012).

> *I do not mind if I was not taught about the topic in the class because I had experienced it so that I can understand the general principles of managing the dead body based on my religion. However, I do not know about the specific tenets of such intervention. I am not sure whether my belief has such particular things. I need to learn more about this matter in the future (…)* (PS-11).

In dealing with matters of dying and death, students and nurse educators shared similar experiences in relation to spirituality. They mentioned that having an opportunity to care for dying patients and to handle the dead body had made them reflect on their own life and death pathways. Such experiences highlight the role of critical reflection as part of transformative learning (Mezirow, 2000), which contributes to an increase in participants' self-awareness and motivation to improve relationships with patients and provide better care. There was also a dialectical relationship between individual agency and sociocultural conditions related to care of the dying and after-death care, whereby educational practices were both reproduced and contradicted by those who experienced them.

5.2.3 Information and support provision

Caring for the grieving family was not commonly seen as primarily a nursing role, although participants agreed theoretically that bereavement care is one of nurses' primary duties in emphasising psychological, social, cultural and spiritual responsibilities. The majority of participants felt that their responsibility to care for the dead body was complete when the body was transferred to the mortuary unit, which suggests that they did not feel responsible for providing aftercare (e.g. emotional support) for the families of the deceased.

The following participant highlighted the importance of preventing unanticipated grief responses from family members. She had decided to make a personal approach to the family in question, without necessarily having learned appropriate techniques:

> *I don't think that I receive enough knowledge and skills of how to support grief family during laboratory practice sessions (…) What I did just (….)*

> *"Please be calm mam", and I gave her a drink (…) I did not talk very much (…) that's all I can do at that time (…)* (PS-08)

In contrast to students' approaches towards bereavement care, nurse educator participants emphasised giving information about the patient's condition and anticipating prolonged grief by providing spiritual support for the family.

> *For bereavement care, I usually give spiritual support and provide information for the family, and also give them an explanation about the patient's condition. If you compare it to the theory, what I do is not ideal yet (…)* (PCI-04)

5.2.4 Standardised clinical practice

Participants indicated that caring for the deceased body should follow specific standards of safety practice. Students mentioned that handling the infectious body was challenging due to lack of knowledge about current practice protocols. Students expressed concerns relating to unavailable clinical practice guidance, particularly among those who were initially involved in after-death care in the hospital.

> *I also left the room as well since I never handle the deceased body before. I only watched outside; I saw the nurses looked confused: 'what happened with this patient? His eyes were yellowish, also his nails…?' fortunately, all the nurses wore gloves when he cleaned his body. Thus, one of them checked his medical status; he had hepatitis C, indeed!' (…) (PS-12)*

The findings thus indicate the distortion of communication and coordination between practitioners and academics, which may contribute to discrepancies in the clinical teaching and learning process.

5.3 Barriers and challenges to establish professional relationships

Professional relationships entail participant's perspective of how an interaction occurs between an agent and the agency which had an important influence on the participants' learning experience. Participants acknowledged difficulties and challenges in establishing caregiving relationships and in teaching-learning interactions due to a variety of personal, professional and organisational factors. Five important elements that impact on establishing professional relationships in practice and in the learning context were identified: communication and relational issues, inadequate preparation and support, student-teacher interaction, reflection and engagement, and social learning environment.

5.3.1 Communication and relational issues

Participants indicated that CDDB was enhanced by effective communication and good interpersonal skills. Difficulties in communicating with the dying patient and the family were evident from the findings. Most student participants had experienced awkward

conversations with dying patients and their families. For example, some reported that families often asked students about patients' prognoses, and that students struggled to offer clear explanations. Students were particularly affected by fear of making mistakes and of being criticised by families.

> *I'd rather keep silent and pray for the patient, than say something unclear. I was also confused when the doctor explained about the prognosis and asked the family to make a final decision whether to continue the CPR or not. The most confusing thing for me was when I saw the family got confused and angry (...)* (PS-12)

Further difficulties in communication were expressed by students when dealing with unconscious and dying patients and their families in the hospital. Only one senior student had no problem communicating with unconscious patients. She associated humanistic care with non-verbal communication, such as touching the hand, rubbing the back, and giving a hug to the family. However, in Indonesia (and many other cultures), communication using physical touch is not always appropriate when dealing with a person of a different gender. Another student thought that touching a patient of a different gender could be unethical. This situation resulted in hesitation and confusion when talking to patients' spouses or other family members of a different gender.

> *(…) When I was dealing with a different gender, I felt a significant hesitancy and was afraid if those manners are not ethically acceptable. I also worry if the patient will misconstrue my efforts to do that (…)* (PS-11)

This indicates that the personal values and beliefs of students can influence their relationships with dying patients and their families. Factors that served as barriers to establishing professional relationships included lack of communication skills, families' unrealistic hopes and expectations, and fears of the unknown. Students felt that nurses should be present with dying patients and their families, but they felt awkward in applying such practice. These stressors often made them feel emotionally exhausted and caused them to minimise their engagement with patients and families.

> *I think nurses rarely get closer with their patients. They just come if the bell is ringing. I did not see the nurses do something to get more intimate with them yet (…)* (PS-07)

Inability to communicate effectively with patients and families appeared to be the biggest challenge among nurse practioners. Such constraints, together with a lack of professional autonomy and care coordination between nurses and physicians, prevented them from achieving mutual goals of care. This situation reflects a lack of professional identify and a power imbalance that undermines nurses' ability to execute their professional roles and responsibilities.

> *(…) We do not have the right to explain the case to the family. We are also afraid if we say one thing but then the doctor says another. The patients and*

> *the family trust the doctors more than us, so yeah... just let it be anyway (…) it was difficult to explain what happened to the family, to make sure they understood why the patient died (…)* (PCI-03)

Overall, a lack of communication skills and inadequate sharing of information impacted on students' and novice nurses' emotional responses when caring for dying patients. Participants reported a need to improve their knowledge and skills so that they might communicate effectively when they deliver bad news, educate families about loss and grief, provide bereavement support, and communicatie within the multidisciplinary team.

5.3.2 Adequate preparation and support

Participants indicated that professional and meaningful relationships were facilitated by appropriate preparation and support during pre-clinical learning. Students reported that major sources of distress included watching patients' pain when approaching the end of life, patients' fears of rejection from family members, and managing the deceased body. However, in current clinical education, there appears to be a lack of formal support for students in managing such negative emotions. The acquisition of relevant cognitive, affective and psychomotor skills among students appears to be 'negotiated', rather than being acquired in the same way as traditional academic knowledge and skills.

Fears of facing the dying patient alone prevented some younger participants from interacting with patients and families in the hospital. Students reported experiencing fear when seeing and caring for the dead body in the ward, and some reported that they were subsequently haunted by the memories of the patient.

> *I only often ask myself, 'is it the smell of the patient?' when there is a similar smell. I often think that the dead patient might still be around or something. Maybe it happened because I handled him in person, so the memory lasted after a while (…) I said to myself, perhaps I was traumatised. Maybe it is because I think about it too much (…)* (PS-13)

Feeling emotionally tense while transferring the dead body to the mortuary unit was further reported by another participant. This student recalled feeling unprepared when accompanying the family to transport the dead body due to a lack of relevant training during the academic programme:

> *(…) I cannot bear to see his face (…) he was so blue, his eyes closed (…) when I held his head, it was still watery. I could not hold my tears when seeing the baby, but I had to carry him in my arms and bring him to the mortuary unit, it was so pitiful indeed! (…)* (PS-02)

Clinical experiences with dying and death can be further viewed as stressors for most undergraduate nursing students and novice nurses. Students and novice nurses often receive inadequate support from their clinical mentors when caring for dying patients or looking after deceased patients. In contrast, some clinical instructors reported a

tendency for students to lack initiative and participate less actively in caring for dying patients on the ward.

> *(…) When it came to giving care to a dying patient, the students rarely took part directly (…)* (PCI-02)

On the whole, the findings further confirm the need to improve clinical nurse educators' capacity in guiding students when caring for dying patients and their families. Students required extensive support from nurse educators to reduce their distress and feelings of grief after exposure to death and suffering. They expected their clinical mentors to be sensitive and be able to recognise their vulnerability. Teachers, therefore, need to communicate compassionately, practise attentive listening, offer emotional support, and follow ethical principles and values in practice.

> *(…) students cannot be incompetent when caring for the dying and dead patient. If they have a negative feeling in the past that may affect their readiness (…) we also need to identify whether the students have a history of losing someone they love and still cannot accept that fact (…)* (PCI-04)

Support mechanisms were identified by participants, and these typically involved informal coping strategies such as engaging in peer conversation or applying humour and jokes during breaks. Perhaps surprisingly, none of the participants had considered utilising formal strategies, such as the counselling services provided by the faculty, to manage their feelings. One participant said that this decision was related to her personal belief that grief is a 'family business', and that it could thus only be shared with her own family. This participant appeared to feel that she was protecting her dignity by not disclosing the suffering to others, perhaps as a social defence mechanism (Menzies, 1980).

> *(…) I did not go to the counselling due to my privacy protection; it is all about my family business (…)* (PS-11)

The most common coping strategy reported by participants was their reliance on their belief in God and their engagement in religious rituals. Participants believed that God had set them challenges or presented them with stressful situations in order to grow spiritually and emotionally, and as a reminder of their own death and the afterlife. The coping mechanisms reported by participants reflected their culture, values and beliefs, and the differing ways in which individuals respond towards loss and grief need to be understood by nurse educators during clinical teaching and learning.

The provision of support and facilitation during clinical teaching and learning can facilitate the establishment of professional and meaningful relationships. Likewise, development of emotional self-control is also essential for establishing professional relationships with dying patients and their families. Therefore, developing nurse

educators' ability to recognise and respond to distress in students following dying and death exposures is crucial.

5.3.3 Student-teacher interaction

Participants indicated that professional and meaningful relationships helped them to feel accepted and empowered during clinical learning practice. Students generally valued the process of clinical supervision, which they felt enhanced their knowledge and skills in dealing with dying patients and their families. However, not all participants encountered such positive learning experiences. One participant reported that some clinical mentors demonstrated unsupportive behaviours, which had impeded their gaining further knowledge and skills in the clinic:

> *The nurses were a bit ignorant, especially when I was doing CCSA (Comprehensive Clinical Exposure Activities) last year (…) the nurses only talked to us when it was the time to do a check-up routine and administered the drugs to the patient (…) They spent most of their time in the nurse station, documenting the patients' status. We were not informed what to do, so we ended up by spending our first day only observing the nurses' activities (…)* (PS-13)

As previously alluded to by nurse educator participants, constraints relating to clinical teaching and supervision in the teaching hospital may be largely attributed to their excessive workloads. This may undermine their availability to conduct clinical supervision and to allocate sufficient time to students. There may be distorted communication between nurse educators and students, which contributes to discrepancies and disturbances in students' educational and clinical practice experiences. In responding to this situation, one student explained her views on enhancing the roles and responsibilities of clinical instructors:

> *(…) I guess they should have an open mind and broad knowledge so that, when we need to ask, or we have a high curiosity about the issue, the nurses have the willingness to answer our questions. They do not ignore us, and even they could punish us if we create some problems. They would also give a chance for us to do one intervention (…)* (PS-01)

Most students expected their clinical mentors to show characteristics of professional role models, such as being knowledgeable and clinically expert, providing clear guidance and reassurance, and being open-minded and approachable. In a practical sense, students needed to have an influential figure who could inspire, nurture and guide them to become professional nurses in the future.

5.3.4 Reflection and engagement

Participants indicated that meaningful engagement during clinical learning and practice was facilitated by critical reflection, involving dialectical relations between agencies (patient/family, students/teachers, and practitioners) as well as internal dialogue (Freire, 1991; Mezirow, 2000). Several participants who were enabled to care for dying patients

reported feeling ‘rewarded’. Another participant obtained positive insights from their relationship with dying patients and their families:

> *(...) through my experience, I can sense others' feeling, and thus I want to share my feeling with other people whom I talk to, because I want to help them and try to ease their burdens (…)* (PS-11).

Participants indicated that positive experiences resulting from dealing with the dying had increased their self-awareness and self-confidence in clinical practice, which in turn improved their own sense of professional identify. Such clinical experiences were discussed in terms of the relationships between students and patients/families, as well as with peers and clinical mentors. Both students and nurse educators found that caring for dying patients during their clinical learning placement had caused them to reflect on their past and future actions. Furthermore, they reported that such self-reflection had helped them to reduce their internal conflict resulting from unresolved loss and grief, and to strengthen their personal relationships with others. Such experiences contributed to improving their understanding of patients' conditions, and consequently providing better care to reduce suffering and the burdens experienced by families.

5.3.5 Social learning environment

The importance of professional and meaningful relationships highlighted the significance of the social environment to the learning experience. Although the vast majority of participants reported positive experiences during clinical practice, some negative aspects were also highlighted by students. For example, there were some clinical learning sites which were not prepared for end-of-life care learning placements (see section 5.3.2), lacked expert mentors in palliative and end of life care (see section 5.3.3), did not provide briefing and debriefing following clinical learning sessions (see section 5.3.2), and/or had limited infrastructures which were highlighted as a negative influence on the student experience. Issues of hierarchy were also raised, with one participant feeling oppressed by the clinical staff, and another feeling intimidated by the patient’s family (see section 5.2.1). In both of these cases, the participant felt undermined and powerless in their clinical practice, and thus their ability to engage in caregiving relationships which promoted learning was limited.

In summary, participants generally experienced CDDB as a meaningful engagement with patients, families and health practitioners. Such events stimulated their self-awareness through critical reflection, thus improving their personal and professional engagement with care of the dying and after-death care. However, several participants identified significant constraints that affected their engagement with CDDB. These were based on personal characteristics, professional practices, organisational supports and social and environmental factors. Adequate support and a positive learning environment are thus crucial in promoting student engagement in learning and strengthening student-teacher interactions.

5.4 Needs for support and facilitation towards professional agency

Participants indicated that professional relationships were enhanced by support and by facilitation of 'agency' in practice and learning. Agency refers to an individual's capacity to perform an autonomous action in the context of his/her social structures (Fitzpatrick, 2016). In this study, agency reflects nurse educators' capacity to conduct their professional roles and responsibilities in the context of teaching and clincial practice. Nurse educator participants reported barriers and challenges in conducting teaching and clinical practice due to inadequate support and facilitation (Brien et al., 2009).

Five critical aspects were shown to reflect nurse educators' needs for support and facilitation in teaching and clinical practice: teaching and mentoring agency, disorienting roles and responsibilities, personal and professional reflexivity, clinical mentoring and supervision, and limited resources and access provision.

5.4.1 Teaching and mentoring agency

Similarly to the student participants, most nurse educators admitted a lack of knowledge and clinical experience surrounding CDDB. Faculty staff thus found talking about dying and death topics very challenging, both in the classroom and in clinical learning settings. This lack of knowledge and experience further constrained their ability to develop teaching content and delivery methods for their students:

> *We do not teach how to care for the critical patient who is dying. For example, the physician has administered noradrenalin with a specific dosage, but the patient is still unresponsive, it is one of the criteria of dying in the critical care area. It was discussed during group tutorial, but we have not yet introduced the topics to the students. We do not know whether it should be embedded in another subject (…)* (PNE-08)

Although all nurse educator participants had had previous palliative care training (as described in Chapter 2), they still experienced difficulties in transferring their knowledge and skills during clinical teaching and supervision. Lack of opportunities to attend professional training, and an absence of practice and learning guidelines, meant that they relied instead on their own personal experience.

Nurse educators reported a need for more continuing education and faculty development programmes that comply with their busy schedules and levels of competence. Identified areas of training need in EoL care included effective communication, clinical assessment, symptom management, and ethical and legal issues.

> *(…) More training should be given. I heard that all lecturers would be given training for palliative care and end of life care since last year, but none of the training was given until now (...)* (PNE-04)

5.4.2 Disorienting roles and responsibilities in clinical teaching

In clinical practice, nurse educators often act both as teachers in the student-teacher relationship, and as advocates in the nurse-patient relationship. Such mixed roles may create confusion and conflict in ensuring that students obtain relevant clinical experience without becoming oppressors of the patients. While nurse educators wanted all students to closely observe dying patients, they also expressed concern about the privacy and safety of patients and families. This poses a potential dilemma for clinical instructors, which may affect the nature of the clinical teaching and learning process.

> *(….) It is because we do not want them to gather around one dying patient to see how to resuscitate. It is not a good thing for the patient and the family to have so many people around. Therefore, we decided to divide them to avoid crowding, because a dying patient is not a spectacle (…)* (PCI-03)

Nurse educators further view nursing education as identical with the 'real-life' learning process (Cleary, 1999) that took place in the clinical settings. This idea was strengthened by practices and standardised procedures that attach to the operational systems as the status quo. However, unsupportive working policy and systems have prevented faculty staff from doing clinical practice as a part of their professional identity as a nurse. One teaching staff member described this experience as follows:

> *(…) We need to prepare everything from A to Z for our classes and lectures (…) with the current condition of performance outcome measures, none of those working performance indicators are related to the clinical working aspect (…)* (PNE-04)

It was difficult for faculty staff to have formal clinical experience, since they were employed by the faculty teachers and clinical supervisors, and yet almost their entire time was spent in the classroom. One faculty staff member reported that inadequate knowledge and clinical practice in EoLC was viewed by clinical instructors as posing a significant challenge in clinical teaching and supervision:

> *I can only describe the concepts to the students (…) If only I had been involved starting from the care planning until the evaluation of the patient during the end of life phase (…) then I would be able to explain in more details to the students so that they could understand more quickly because the "feeling" is there.* (PNE-04)

There is an assumption that professional nurse educators are expected to have worked in different areas, and thus demonstrate various clinical skills, in order to maintain their professional credibility. As one of the clinical instructors explained, a nurse educator is ideally 'working as a double agent':

> *Lecturers should also be experienced being in that position, at least to feel and see what it is like giving care to dying patients. If they only know the*

> *theory about it, it will be different when they deliver it to the students (…)* (PCI-01)

The findings further indicated feelings of anxiety, distress and lack of self-confidence among nurse educators towards CDDB as a result of their lack of professional training and clinical experiences.

5.4.3 Personal and professional reflexivity

Most nurse educator participants reported positive reflections on their experiences in dealing with DDB and how they related this to their plans for future working and practice, feeling 'rewarded', and a 'sense of worth'. All participants referred to their personal experiences as having influenced the ways in which they thought about and approached their work as faculty staff or clinical instructors.

Some nurse educators, regardless of age, working experience, educational training, culture or religious background, experienced fears of the unknown. One senior clinical nurse instructor mentioned her 'fears of own death' when recounting a near-death experience, and reported that such experiences had increased her own level of spirituality and religiosity:

> *(…) I am afraid if I die without having spiritual preparation and being kept as a sinner when the death is coming to me (…) we never know when we would die for sure, so yeah (…) it worries me sometimes (…) I must remember this so that I could prepare myself better than before (…)* (PCI-02)

Such a situation reflects that cultural and spiritual values can influence how nurses cope with negative emotions resulting from their clinical practice. Self-awareness in relation to dying and death can be further facilitated by student-teacher interaction. One faculty staff member reported that she learned how to cope emotionally and spiritually when facing death while establishing a personal relationship with her grieving student. She immersed herself in her students' sufferings, which blurred her professional boundaries:

> *When I visited her at home (…), she was an adamant person (…) I cannot imagine what would happen to me if I was in the same situation with her (…) perhaps, I would cry heavily and don't know what to do (…) However, she was managing her sadness while supporting her siblings alone. I learnt a lot from her, indeed (…)* (PNE-01)

Some participants reported positive and meaningful experiences in providing personalised care for dying patients and their families. They valued having seen the patient die without any difficulties in the trajectory of dying, and accompanied by their family members, and viewed this as a 'good death'. Their feelings of 'sense of worth' were strengthened when they had established meaningful relationships with dying patients and their families. However, participants were also aware that such ideal situations could often be hindered by constraints such as the application of aggressive

treatments, negative attitudes of colleagues, inadequate emotional and social support, and limited sharing of information with families.

5.4.4 Clinical mentoring and supervision

On the whole, the majority of students had inadequate exposure to care of dying patients and care of the deceased body, as these had not been included as clinical learning objectives. Hence, students were often depended on their clinical mentors to learn CDDB-related knowledge and skills, as a form of learning by socialisation.

> *(…) We did not discuss death and dying. We just talked about why it was IUFD (Intra Uterine Foetal Death) (…)* (PS-08)

Lack of opportunity to address students' clinical experiences when facing dying, death and the bereaved family with their mentors was further evident. Participants received varying, and sometimes conflicting, information from their clinical mentors, leading to difficulty comprehending clinical issues and determining appropriate interventions.

> *Since different mentors provide different information, one says you should learn this and that, but others may mean you need to learn this and this. I think it would be better if the students can have faculty and clinical mentors who are 'in the same frame' (…)* (PS-11)

Participants reported that the process of debriefing after dying and death exposures was not always accommodated, resulting in dissatisfaction among students with the quantity and quality of acquired clinical knowledge and skills. All students expressed a need for improvement in the knowledge, attitudes, and skills that would enable them to care for dying patients and their families and provide after-death care. Students placed particular value on emotional and mental preparation before entering clinical learning placements, particularly for those without experience of caring for the dying:

> *In my opinion, the faculty needs to prepare and then strengthen the student's emotions and mental capacity before we met the patients. For example, how we should behave when we care for the elderly, and how we should act when we reach the dying patient (…)* (PS-01)

Although faculty staff and clinical instructors played an important role in clinical learning placements, there seemed to be no standardised consensus on conducting student mentoring and supervision. In some wards, clinical instructors provided a supportive learning environment for students. Other students received inadequate support and facilitation, largely due to mentors' workloads, time constraints, and lack of trained mentors in CDDB

5.4.5 Limited resource and access provision

The findings indicated that the teaching and mentoring agency of nurse educators was facilitated by providing adequate resources and access. Organisational factors that

influenced the teaching and learning process included time, staff workload, policy/guidelines, and facilities. Nurse educators found that their heavy workloads and lack of time prevented them from guiding students during clinical learning practice, as described by one faculty staff member:

> *(…) the schedule should be thought though carefully, as our program is already tight (…)* (PNE-04).

Participants' difficulties in caring for dying patients in clinical practice were often caused by an absence of standardised procedures, as previously referred to in section 5.2.4. Both students and nurse educators expressed a need for specific protocols and practice guidelines that focused on EoL assessment, pain and symptom management, communication, spiritual care and bereavement care. Participants were further concerned about methods of handling the dead body, particularly in cases of infectious diseases:

> *We need this because we cannot leave the body as it is. We need to clean it properly and handle it as required. We need to stitch the wounds and replace bandages if needed. Things like this should be in the SOP and must not be missed, as the family of the deceased will want it to be done correctly (…)* (PCI-03).

Both faculty staff members and clinical instructors reported that teaching in the clinical setting was not always conducive to learning. Some students felt prevented from freely expressing their trauma or other negative emotions after exposure to dying and death. Nurse educators also lacked opportunities to properly evaluate what had been learned and experienced by students:

> *(…) The ward usually looks busy, so when I want to discuss something with a patient, I do not feel comfortable and cannot talk freely. Perhaps, we need a specific room for discussion in the ward (…)* (PNE-09).

Providing suitable teaching and learning infrastructure is imperative for establishing successful teaching and learning processes. Language barriers may prevent students from understanding materials obtained from textbooks and online sources. Students felt that faculty management should consider making available learning infrastructures such as information resources written in a local language, simulation laboratories, relevant clinical learning sites, and discussion rooms for pre- and post-conference activities, including briefing and debriefing:

> *I find it difficult to find any resources in the library (faculty) (…) I have searched on the websites (…) most of them used English (…)* (PS-05)

Students and nurse educators shared similar perceptions and expressed similar needs relating to improving the current teaching and learning approach. Overall, participants

agreed that facilitating change and transformation could be promoted by negotiating curriculum content and pedagogy practice with users and stakeholders.

5.5 Negotiating curriculum and pedagogy practice

Curriculum documents as an end-product often reflect a negotiation process among developers and users (Fitzpatrcik, 2016). Participants agreed that an exploration approaches CDDB in nursing education is highly important. However, clear explanations of what constitutes CDDB, and how such care is delivered, were often lacking, since such topics were often less prioritised than the core competencies in undergraduate nursing (as discussed in Chapter 2). Thus, negotiating curriculum and pedagogy should be facilitated through examining incongruent learning experiences, the need for content negotiation, and transforming frames of references.

5.5.1 Incongruent learning experiences

Almost all faculty staff and clinical instructors said that CDDB needed to be contextualised when integrating it into the curriculum. The contextualisation of CDDB relates to its placement within the wider context of a particular academic course, ensuring that students can see its relevance as an integral part of their learning journey. Participants acknowledged that the integration of theory and practice on CDDB was important, but reported that learning materials and practice skills relating to dying and death were limited, both in their pre-clinical and clinical training.

> *As nurses, we are often asked to do things that are different from what we learned in the academy (…) I did not get it even when I was taking my professional course, but I handled the dying patients after I finished the course (...)* (PCI-03)

Participants felt that the theoretical knowledge and skills learned in the classroom and laboratory were different from those applied in clinical practice. Likewise, a number of participants reported experiencing difficulties in differentiating between palliative care and EoLC, or knowing when and how such knowledge should be transferred to the clinical practice setting.

> *We only focus on doing clinical interventions, which is not palliative care. So, it was superficial, and thus we become 'blanked' about how palliative care is given (…)* (PS-08)

Nurse educators acknowledged that this situation was caused by a lack of contextualisation of CDDB in the current curriculum, and a lack of information and dissemination about professional roles and responsibilities in clinical placements. Teaching staff members highlighted the importance of improving current institutional policies and curriculum guidelines, and suggested that an ideal curriculum should include core competencies, learning outcomes and relevant content relating to EoLC.

Both students and nurse educators felt that experiential learning could be a good method of sharing such experiences and reflecting on practice, for example, via small group discussions, role play or simulation based learning, applying a comprehensive evaluation to ensure that students' targeted competencies were met.

> *(…) we learnt about palliative care, but we do not know how to do it practically (…)* (PS-09).

> *We cannot do a direct practice to the patient because there are many advanced nursing interventions (…) I think using a simulation learning is applicable to learn about the CDDB (…) the students can see how the patient is dying and finally dies (…) (PNE-6)*

5.5.2 Need for content negotiation

Content negotiation is a further important process intended to influence better pedagogy practice (Kern et al., 2009). Curriculum content and course guides, as discussed throughout this study, may be viewed as 'negotiated documents', reflecting a process of negotiation that can be achieved at various levels through the agency of students and nurse educators. As discussed in chapter 2, dying and death issues are a hidden agenda in almost all nursing practice and education (Johnson, 2009; Condon et al., 2014), including in the current undergraduate curriculum.

> *I was just graduated from an academic programme, that was one more reason to feel panic and confused (…) my patient suddenly died after I gave him an injection. I did not know what to do with the corpse (…) I did not know where to tie the knots, so I ended up calling the head nurse (…)* (PCI-02)

Nurse educator participants confirmed that current professional nursing organisations do not consider CDDB a priority subject, although dying and death are frequently experienced in clinical settings. They suggested that, in addressing CDDB content in nursing education, content negotiation may be achieved by developing specific learning outcomes, to be implemented through the integration of learning experiences in the classroom and in clinical learning.

Nurse educator participants argued that developing CDDB competencies appears to be a priority agenda in order to fill the gaps of the current nursing curriculum. Having clear, standardised core competencies for students helps curriculum developers and teachers to develop learning outcomes and objectives that are achievable and measurable (Kern et al., 2009).

One participant emphasized the importance of such core competencies in CDDB, as follows:

> *(…) the lecturers should have similar competencies regardless of whether they come from the maternity, mental health, or community health department (....)* (PNE-10)

However, whilst most participants were aware of the importance of CDDB as the foundation of nursing practice, some raised the ethical and moral issues that need to be considered. For example, there were concerns that the formalisation of CDDB in clinical learning may lead to 'dehumanisation and oppression' in relation to issues of dying and death. Participants agreed that the promotion of EoLC as a tangible practice can be facilitated by enabling key competencies that cover the knowledge, attitudes, skills and values necessary to care for patients and families during the dying stage and death, and after death. Such competency concepts were originally proposed by Smith-Stoner (2011). Both students and nurse educators were concerned that students might not be able to achieve the core competencies within the limited clinical practice opportunities available. One suggested solution to this was that these clinical competencies should be judged as 'non-compulsory':

> *(…) So that we feel obliged to meet the patients, but do not make it as a compulsory target. At least, the students at the end of their clinical learning, they could take care of the patients who are dying or dead (…)* (PS-08)

Students and nurse educators held similar views regarding the integration of topics about dying and death into relevant subject areas, and thus helping to prevent an overburdened pre-clinical curriculum. Several undergraduate courses relevant to CDDB were proposed by participants, such as the fundamentals of nursing (PS-05), medical-surgical nursing (PS-06), critical care (PS-11), gerontology nursing care (PS-01), and mental health and psychiatric nursing (PS-13). The integration of learning into all clinical nursing rotations could also be a means of improving opportunities to encounter CDDB during clinical placements. However, there may be a limited potential for clinical exposures towards dying patients, and this situation requires further attention from faculty administrators and nurse educators.

> *I think it is because dying patients are rarely found in the maternity unit. Only some students would have a chance to care for the dying patient, so not all students will be able to achieve the competency. However, there are other units where it is possible to find more dying patients (…)* (PNE-10).

Not all nurse educators agreed that curriculum integration could solve the problem of the current gap in CDDB practice and education, and some instead argued that, rather than being integrated into existing subjects, CDDB education could be provided separately as a part of current EoLCE. One such nurse educator emphasized the complexity of the end of life stage, with its focus on illness prognostication and multifaceted caregiving issues.

> *Attaching the topic in another subject such as medical-surgical nursing can be challenging. It is because more chronic diseases are discussed in the medical-surgical nursing area (…) it is more acute care than critical one (…) there are no specific such parameters of dying state (…) it is challenging to incorporate them (…)* (PNE-08)

All student participants realised that they might encounter dying patients before completion of their clinical learning programme, and therefore felt that there was a need for them to learn about CDDB during the pre-clinical programme. Students were interested in the use of interactive teaching and learning approaches, using various methods such as real case scenarios, small group discussions, films, role plays, simulation learning, community engagement and blended learning.

> *I do not mind with classroom teaching, but since most students are late teenagers, sometimes we still quickly get bored when listening to our lecturers. It would be better if we can have a small group discussion as well (…) This small group discussion can be used to explore the needs of a patient who is dying or death and how to deal with his/her family (…)* (PS-11)

5.5.3 Transforming frames of references

Transforming frames of reference in clinical teaching and learning is a further important aspect of negotiating curriculum and pedagogy practice. Frames of reference represent habits of mind and points of view that underline personal actions (Mezirow, 1991). In the findings of this study, values, attitudes, beliefs, social norms and spiritual aspects were all factors that shaped the agency of student and nurse educators when facing dying and death issues. Participants perceived that the current healthcare service was focused on the biomedical orientation rather than a holistic approach to end of life care (see Chapter 1).

> *We never had any tutorial about cases related to care of the dying and bereaved. I do not know why? (…) Is it because we expect all of our patients will be fully recovered so that we never discuss a dying patient? (…) Thus, we never discuss such cases during our academic and clinical learning process (…) interestingly; such an important thing is often missed by us (faculty staff) and practitioners (…)* (PNE-06)

This in turn affects the way in which nursing education prepares students in both classroom and clinical learning settings. Hence, the current curriculum still values a curative healing approach, rather than focusing on compassionate and dignified end of life care.

> *The recent pre-clinical preparation programme that I followed mostly focused on invasive treatments. We did not get anything about care of dying and death (…) (PS-11)*

Optimal clinical performance cannot be facilitated if there is a lack of a cultural- and spiritual-based caring approach and a prevailing viewpoint that dying and death are ‘medical failures’ (Kellehear, 2013). Indeed, one clinical instructor argued that current social beliefs relating to medical and health care as a panacea also play a significant role in preserving the status quo in nursing practice and education:

> *We can say that Indonesian people need to go to the hospital for curing their illness (…) they think that it will cure them, although, for some cases, it will not happen at all. Therefore, their ways of thinking must be changed until they know that dying patients do not only need medical care, but also spiritual care (…)* (PCI-04)

Several nurse educators shared further thoughts regarding the importance of beliefs and values in clinical learning and supervision. Some were aware of the need to remind students that care of the dying is not about life-saving protocols, but about preparing the patient to achieve a good death and assisting the family by preventing them from experiencing prolonged grief. They further suggested that faculty staff or clinical mentors should remind their students of the importance of providing humanistic care and maintaining patients' dignity. For example, they reminded the students to recite a prayer in their heart when doing CPR and when caring for dying patients on the wards:

> *(…) I asked my students to do talqin (reciting La Illaha Illalah) during CPR and giving other clinical interventions in the ward (…) such an effort can help the patient to die with dignity. Unfortunately, they often forgot it, since they focused on clinical intervention (…)* (PNE-04)

Caring for patients at the end of life requires interdisciplinary teamwork, involving nurses, doctors and other allied health practitioners. Participants agreed that care coordination influences the quality of care provided for dying patients and their families in hospital. However, the lack of professional identity of nurses challenged the establishment of interdisciplinary teamwork in EoLC. Such situations were seen as being unconducive to creating a good clinical learning atmosphere for novice students, as previously alluded by both students and nurse educators (see section 5.3.1).

Participants often felt powerless to challenge the taken-for-granted nature of biomedical hegemony practice. The presence of incongruencies in classroom and clinical experiences, and power struggles in the education process, may contribute to unequal learning experiences and under-developed student competencies. Such a situation further contributes to the widening gap between practice and education, which may inhibit the legitimacy of knowledge and practice as well as nurses' competency in CDDB.

Nurse educators thus suggested that inter-professional education could be a solution when planning and delivering dying- and death-related topics. They believed such an approach could enhance the quality of teaching and learning, as well as curriculum development, implementation and evaluation. Inter-professional education would similarly support the development of student engagement in practice and learning, as well as enhancing the professional capacity of nurse educators.

5.6 Conclusion

Individual in-depth semi-structured interviews were conducted with two groups from the same organisation: 13 undergraduate nursing students (PS) from different entry levels (years 3, 4 and 5), and 17 nurse educators (teaching staff (PNE) and clinical instructors (PCI)). All participants were female. The majority of participants were Muslim (27/30, 90%) with a further three (10%) Christian. No other official religions in Indonesia (e.g. Buddist, Hindu) were represented. Furthermore, this study included participants representing four major ethnicities (Javanese, Sundanese, Padangnese and Bataknese).

Numerous and diverse challenges confronted students and nurse educators when providing care for dying patients and their families in the hospital setting. It was apparent that, at present, neither students nor nurse educators feel fully competent to deal with dying, death and bereavement. Both students and nurse educators perceived that they possessed inadequate knowledge and practice skills relating to CDDB. Students felt that they lacked the power and professional competence to offer advice and support to patients and families, and many reported experiencing significant anxiety and distress as a result.

Nurse educators realised that their inadequate teaching and mentoring capacity affected their ability to respond to students' inquiries and to help improve their understanding of caring for dying patients and dealing with death. Nurse educators were aware of the need to improve their personal and professional reflexivity to support student engagement in practice and learning. It was apparent that improved provision of and access to learning resources is needed, along with better support and facilitation, in order to promote professional relationships and in turn contribute to meaningful learning experiences.

Participants advocated professional relationships between students, teachers, patients/families and other practitioners, as well as calling for a more supportive and facilitative environment, as strong motivations to engage in practice and learning. Participants also valued holistic care, the inclusion of patients and families in care planning and decision making, non-judgmental approaches to patient-family choice, and interdisciplinary teamwork. Their focus on the humanistic and cultural dimension led them to prioritise human dignity for patients and their families at the time of their dying and death.

Participants acknowledged the strong social, cultural and spiritual influences that affected approaches towards issues of dying, death and EoLC. The majority of participants reported using tacit knowledge and spiritual awareness in their provision of care. Hence, all participants expressed an interest in further learning opportunities to allow them to gain competence and confidence in CDDB. They found that clinical

exposures with dying patients and the deceased helped them to review, self-monitor and understand the cases they were presented with, as well as to think more objectively and reflect on their values.

In conclusion, CDDB may currently be considered somewhat of an outlier in the conventional paradigm of nursing practice and learning, being part of a ‘hidden curriculum’. There is a need to clearly identify the ideal curriculum content and pedagogical practice relating to CDDB, in order to increase its relevance to current nursing education. Furthermore, the findings indicate that culture and religious beliefs influence nurses' competence in caring for people at the end of life in Indonesia. Culture, beliefs and norms are existential issues that need to be discussed during undergraduate training.

The next chapter describes the identification of CDDB-related curriculum content in the context of nursing education in Indonesia.

6 Exploring the Content of Indonesian Nursing Curriculum

6.1 Introduction

This chapter reports the findings from stage three of the study, addressing research question three: 'What is the suggested content relating to CDDB in the undergraduate nursing curriculum in Indonesia?' From the analysis of the interviews, the deficits of CDDB-related content in both classroom and clinical learning are evident. The findings confirm the need to restructure the current educational programme to address such issues, and to analyse existing curriculum implementation in order to identify intended, delivered and received curricula (Kern et al., 2004). Thus, curriculum mapping helps to identify any missing or overlapping content within an educational programme (Harden, 2001).

Harden (2001) defines curriculum mapping as a consideration of '*when'*, '*how'* and '*what'* is taught, as well as the assessment measures used to identify student learning outcomes. Harden identified two main functions of curriculum mapping: to facilitate curriculum transparency to all stakeholders, and to show the alignment of curriculum components. Overall, curriculum maps can help in three primary ways:

- Identifying whether the intended material is being taught, and establishing whether this furthers students' learning.
- Demonstrating the links between different critical components of the curriculum (learning outcomes, learning opportunities, content, and assessment).
- Examining specific portions of the curriculum (such as learning location, learning resources, and timetables), and examining the curriculum from multiple perspectives (Harden, 2001; Wachtler et al., 2003; Kern et al., 2009; Van Zyl, 2019).

6.2 Methods

This study aimed to provide an in-depth understanding of how, and to what extent, the curriculum is implemented in the exemplar nursing faculty of Universitas Padjadjaran. The choice of this approach was based on use of the Indonesian national undergraduate nursing curriculum (AINEC, 2010; 2015) as a guide to course design at the faculty level. Rather than involving many institutions, focusing on one single nursing school can help to explore curriculum implementation in more detail.

This study adopts a multimethod approach combining curriculum document analysis and focus group discussion, as described in Chapter 3. Existing curriculum content was identified, based on one nursing faculty, and the broader perspectives of key

stakeholders were explored on essential curriculum content (see sections 3.4.3 and 3.4.4). Descriptive data were analysed using thematic content analysis and constant comparison (Miles et al., 1994; Fram, 2013) as described in section 3.6. Following Kern's step 2, which focuses on identifying targeted need assessment, the curriculum data are discussed below according to the planned, delivered and received curriculum content, with the aim of identifying gaps in the curriculum. Exploration was also carried out of the taught, implicit (hidden) and null curricula in relation to classroom and clinical learning (Kern et al., 2004; van Zyl, 2019). The identified content from previous findings (studies 1 and 2) was further compared and contrasted with the content generated from the faculty curriculum mapping and focus group discussion (see section 6.2.1). The results of these combined studies are expected to inform future recommendations for generating a curriculum framework (Wachtler and Troien, 2003).

6.3 Findings of faculty curriculum review

This section describes the key findings of the faculty curriculum mapping exercise, discussing the intended, delivered and received curricula as emergent from the faculty curriculum documents. The following section (6.4) focuses on the findings of mix documentary and interview findings from focus group discussion with key informants.

6.3.1 The intended curriculum

The intended curriculum constitutes the intention of national curriculum planners regarding the competencies that students must achieve (Harden, 2001). It clarifies the intentions for learning, encompassing the rationale, philosophy and vision of the curriculum (Kern et al., 2004), as well as the goals, topics, sequence, proposed methods and modes of assessment for learning (Van Zyl, 2019).

In the faculty studied, the implementation of a new curriculum of undergraduate nursing, dated 2015, commenced at the end of 2017. The curriculum documents that were evaluated in detail in this study were primarily those from the previous (2010-2015) version of the curriculum, which had been utilised by student participants from the third, fourth and fifth years of the programme (see section 3.6.1). The new (post-2015) intended curriculum was also included in the curriculum mapping process, in order to identify gaps between the old and new curricula and to facilitate the contextualisation of the curriculum. Both curricula adopted the competency-based approach (CBE), as discussed in Chapter 2. However, it should be noted that significant differences were identified between the old and new curricula, including revised learning outcomes, additional subjects, teaching and learning credits, and learning sequences (AINEC, 2015).

Following the framework identified from the scoping review of international literature (see section 2.4.4), only eight out of the 24 core competencies in the national curriculum

were found to be relevant to CDDB. These competencies were translated into nine learning outcomes, embedded into 13 subjects, in the pre-clinical learning programme (see table 14).

Some subjects were offered during the first and second years of study, with fewer offered during the third and fourth years. For example, participants reported studying Fundamentals of Nursing (FON 1, 2, 3), including the concept of dying and death, as part of an introduction to palliative care. However, these subjects focused on theoretical components, rather than on necessary nursing skills (e.g. vital signs, personal hygiene, patient safety), communication skills or psychosocial/cultural aspects in healthcare practice.

These findings were thus consistent with those of the Asian scoping review, which found that most nursing schools delivered dying- and death-related topics in the first and second years of study. The interviews confirmed similar results, with most students receiving tuition on the concept of dying and death, communication, ethics and legal issues, during the first year of study (see section 5.3.1). No further discussion or extending topics were presented in the advanced semesters, resulting in minimal retention of teaching materials during clinical learning practice, as reported in the interview findings (see section 5.5.1).

In terms of teaching and learning methods, student-centred learning, active learning and problem-solving activities were commonly used, as described in the majority of course study guides (FoN Unpad, 2015). However, death- and dying-related topics were more often delivered using lecture-based teaching, with less emphasis on active learning methods such as group tutorials or skills lab activities, as confirmed by other studies (Cavaye et al., 2014). Most topics in this subject area were not further assessed using either objective or subjective assessment tools. Only one subject, ‘Religion’, had specific allocated learning objectives and assessment methods. This utilised group presentations, as well as individual skills assessment, as reported by one teaching staff member and as confirmed in the written syllabus (see section 6.3.2).

Three additional competencies relating to CDDB (i.e. effective and therapeutic communication, infection control and patient safety, and interprofessional collaborative practice) were added to the new curriculum of 2015, with learning modules in this area increasing from 0.64% to 2.8%. Palliative care and end of life care became a discrete subject, however, some content relating to CDDB was distributed into other related subjects. The delivered and received curricula could not be evaluated for these newly-added competencies due to the fact that curriculum implementation was incomplete when the data collection was carried out. However, from the document analysis, it can be inferred that CDDB has indeed been accommodated in the new curriculum.

Table 15 The intended curriculum during pre-clinical learning of 2010-2015

National competency themes	*Content covered*	*Learning outcomes in the curriculum*	*Content covered in the faculty*	*Module*	*Year*	*Teaching approach*	*Assessment methods*
Apply the principles of ethics and legal in nursing practice	Principles of ethics in healthcare and nursing practice Legal practice in nursing Ethical decision making Ethical issues in nursing Nursing advocacy	Utilise principles and concept of ethical, moral and legal to perform the professional nursing practice	Euthanasia; Ethical decision making in nursing; Professional and ethical issues and dilemma	Fundamentals of Nursing II	1	Lecture Case study	Multiple choice
Establish interpersonal relationships	Culturally sensitive care Building self-awareness Applying a holistic care approach in nursing (bio-psycho-socio-spiritual) Apply concepts of transcultural nursing	Utilise concepts and philosophy of religion to provide nursing care	Beliefs and value; Meaning of dying and death in Islamic perspective; Care of dead body in Islam; Spiritual care in Islam; Blood and organ transplantation	Religion in Nursing	1	Lecture Demonstration	Multiple choice Practice test
		Recognise the concept of EoLC to develop the accompanying programme for patients and families	Concept of death and dying; EoLC (physical, mental, spiritual, and religious) and its care strategies; Spiritual care approach to preparing dying patients to reach dignity in death	Fundamentals of Nursing I	1	Lecture	Multiple choice
Provide health education	Teaching and learning strategies	Provide health education but not applicable to PEoLC	Philosophy of teaching and learning, pedagogy practice	Fundamentals of nursing III	2	Lecture Group tutorial	Simulation

National competency themes	*Content covered*	*Learning outcomes in the curriculum*	*Content covered in the faculty*	*Module*	*Year*	*Teaching approach*	*Assessment methods*
Perform effective communication	Communication technique The use of self to communicate Application of therapeutic communication in particular condition (ICU)	Demonstrate skills of effective communication in any setting	Effective communication; Therapeutic communication; Breaking bad news is not applied	Fundamentals of Nursing II	1	Lecture Role play	Multiple choice Practice test
Conduct professional nursing practice in the clinical and community settings	Nursing process Clinical nursing skills Collaborative practice Maintain a supportive environment	Able to make nursing care plan using the scientific method	Not applied in the context of PEoLC	Fundamentals of nursing III	2	Lecture Group tutorial	Essay
Apply the concept of leadership and management in nursing practice	Situational need analysis Flow of care Care coordination Quality nursing practice	Apply the concept of leadership and management in nursing practice	Not applied in the context of PEoLC	Nursing Management	4	Lecture Group tutorial	Not applicable
Cultivate life-long learning ability and practice	Critical thinking in nursing Evidence-based practice in nursing	Cultivate life-long learning ability and practice	Not applied in the context of PEoLC	Fundamentals of nursing III	2	Lecture Group tutorial	Not applicable
Conduct a simple research	Research process	Conduct a simple research	Not applied in the context of PEoLC	Research in Nursing	4	Supervision	Not applicable

Table 16 CDDB-related competencies and subjects in the new curriculum (post 2015)

National competency theme	Subject		Semester
	Discrete	Related	
Ethical and legal issues in nursing practice		Fundamental of Nursing (n=1)*	1
Professional nursing practice		Basic Nursing Concepts (n=1)*	1
Spiritual care		Religion in Nursing (n=1)*	1
Health education and promotion		Health Promotion in Nursing (n=1)*	2
Personal and professional development		Personality Development (n=1)*	2
Effective and therapeutic communication		Communication in Nursing (n=1)*	2
Care of terminal illness	Palliative and end-of-life care (n=8)*		4
		Paediatric Nursing (n=1)*	5
		Older Person Care (n=1)*	6
Leadership and conflict management		Nursing Management (n=1)*	4
Infection control and patient safety		Patient Safety in Healthcare Practice (n=1)*	6
Interprofessional collaborative practice		Interprofessional Education (n=1)*	6
Research and evidence-based practice in nursing		Research in Nursing (n=1)*	7

Note: *number of learning module

For the clinical learning phase, following the developed framework (see section 2.4.4 and 4.1.1), eight system blocks and ten related contents were embedded in the clinical learning modules of the pre 2015 curriculum. However, only one of the modules contained an explicit learning objective to care for terminally ill patients, as shown in Tables 16 and 17. Seven major nursing areas were identified in which students are often exposed to dying and death: paediatrics, maternity, medical-surgical, critical care, emergency nursing, gerontology nursing and family health nursing. During the clinical learning phase, communication is one of the essential skills used in most areas, followed by the nursing care plan, science-based knowledge, ethical and legal issues, and cultural-spiritual care.

Table 17 The intended clinical learning programme of 2010-2015

Name of the clinical learning module	*Year/ Semester*	*Themes in practice modules where DDB can explicitly or implicitly include*	*Context*
Clinical exposure (CCSA)	3/6	Primary nursing care; Therapeutic communication; Terminal care	Clinical practice
Medical-surgical nursing	5/1	Care of terminal illness patient*; care of the dead body	Hospital-based
Paediatrics nursing	5/1	Children with a terminal illness; family-centred care	Hospital-based
Maternity nursing	5/1	Perinatal/neonatal death	Hospital-based
Mental health nursing	5/1	Therapeutic communication; psychosocial care	Hospital-based
Critical care, emergency and disaster management	5/2	Care of the dying patient in the ICU and ER settings	Hospital-based
Community health nursing	5/2	Care of the dying family member at home care	Community-based
Gerontics and family health nursing	5/2	Family-centred care; care of dying older adults in aged care	Community-based
Nursing management	5/2	Clinical leadership; Interdisciplinary teamwork	Hospital-based

* Represents explicit learning objectives in the clinical learning guidelines

Table 18 The intended clinical learning programme of post 2015

Name of the clinical learning module	*Year/ Semester*	*Themes in practice modules where DDB can explicitly or implicitly include*	*Context*
Clinical exposure (CCSA)	3/6	Primary nursing care; Therapeutic communication; Terminal care	Clinical practice
Medical-surgical nursing	5/1	Care of terminal illness patient*; care of the dead body	Hospital-based
Paediatrics nursing	5/1	Children with a terminal illness; family-centred care	Hospital-based
Maternity nursing	5/1	Perinatal/neonatal death	Hospital-based
Mental health nursing	5/1	Therapeutic communication; psychosocial care	Hospital-based
Critical care, emergency and disaster management	5/2	Care of the dying patient in the ICU and ER settings	Hospital-based
Community health nursing	5/2	Care of the dying family member at home care	Community-based
Gerontics and family health nursing	5/2	Family-centred care; care of dying older adults in aged care	Community-based
Palliative care	5/2	Communication, symptom management, decision making, spiritual care	Hospital-based
Nursing management	5/2	Clinical leadership; Interdisciplinary teamwork	Hospital-based

* Represents explicit learning objectives in the clinical learning guidelines

6.3.2 The delivered curriculum

The delivered curriculum refers to the way in which the curriculum is implemented in practice through teaching and learning, including how it is influenced by the perceptions and interpretations of its users (nurse educators) (Kern et al., 2009; Van Zyl, 2019).

In order to explore the criteria set by FoN Unpad for assessing students' competency and skills in addressing EoLC needs, 13 undergraduate nursing courses were reviewed, along with the faculty handbook of 2014-2015 (see table 19 and 20).

Table 19 The delivered curriculum in the period of 2010-2015

Year	*Course/ Module*	*Domain*						
		1	2	3	4	5	6	7
Pre-clinical								
1	FON1							
	FON2							
	RELIG							
2	PERSN							
	FON3							
	MHN							
3	GERONT							
	CNP I							
4	NURMGT							
	FAMNUR							
	NURES							
Clinical								
3	CCSA I and II							
5	MEDSUR							
	PEDR							
	MATER							
	MHN							
	CRITIC/ER/DIS							
	CHN							
	GERONT/FAM							
	NUR-MGT							

Note:

Domain 1: Knowledge and philosophy

Domain 2: Ethical and legal issues

Domain 3: Psycho-socio-cultural-spiritual aspect

Domain 4: Communication and interpersonal skills

Domain 5: Management of symptoms at the end of life

Domain 6: Bereavement care

Domain 7: Personal and professional development

Table 20 The delivered and received curricula of 2010-2015

Year	*Course code and title*	*Learning outcomes*	*Content related to the CDDB*	*Taught contents in the classroom learning logbook*	*Taught content in the clinical learning guides*
2012/ 2013	Fundamentals of Nursing I	Apply the principles of nursing to develop professional conducts and serve clients and others through a humanistic approach in different health settings	Essence of nursing Roles and function as nurses Caring in nursing Cross-cultural in nursing Spirituality in healthcare Stress and adaptation	Not related to the contexts of caring the DDB	CDDB not mentioned
		Recognises the concept of the EoLC (physical, mental and spiritual) to develop an accompanying programme for patients and families.	Concept of death and dying EoLC (physical, mental, spiritual and religion) and its care strategies Spiritual care approach to preparing dying patients to reach dignity in death	Sign of death and dying Needs of nursing care for dying patients and their families Care of dying patients	Idem
2013/ 2014 2014/ 2015	Fundamentals of Nursing II	Utilises principles and concept of ethical, moral and legal in nursing in an attempt to perform professional conducts.	Euthanasia Ethical analysis and decision making in nursing Professional, ethical issues and dilemma.	Euthanasia Ethical analysis and decision making Professional, ethical issues and dilemma	Idem
		Demonstrates skills of effective communication in any setting	Beliefs and value of cultures Effective communication Therapeutic communication Communication in special conditions	Beliefs and value of cultures Effective communication Therapeutic communication Communication with the patient in the ICU	Idem
2013/ 2014	Fundamentals of nursing III	Develop a nursing care plan using the scientific method	The perspective of nursing practice: care of terminal illness, dying and death Nursing assessment Education in nursing	Psychodynamics of illness (acute illness, chronic and terminal illness, death and dying, spiritual needs) Physical assessment Health education	Idem
2012/ 2013	Religion in Nursing	Apply the concept and skills related to Islamic religion in caring the patients at the end of life	Meaning of dying and death in Islamic perspective Care of the dead body in Islam Spiritual care in Islam	Meaning of dying and death in Islam Care of dead body in Islamic perspective	Idem
2013/ 2014	Comprehensive Clinical Skills Analysis (CCSA) 1	Apply and providing nursing care focused on personal hygiene and safe environment	Maintaining personal hygiene Providing a safe environment	In conjunction with basic nursing sciences and the relevant block system	Idem

Year	*Course code and title*	*Learning outcomes*	*Content related to the CDDB*	*Taught contents in the classroom learning logbook*	*Taught content in the clinical learning guides*
2014/ 2015	Personality Development	Demonstrates professional nursing images through the development of self-concept and motivation	Self-concept Intelligence: emotional, spiritual, and social Norms and values in nursing Adversity quotients and resilience Time management Positive thinking	Not related to the contexts of caring the DDB	Idem
	Neurobehavioral in Nursing I	Not specified	Introduction to the concept of palliative care	Definition of palliative care Roles and responsibility of palliative nursing	Idem
			Psychosocial issues	Psychosocial problems	Idem
	Community Nursing I	Apply and providing nursing care for the family with high risks developing health problems	Family health assessment Psychosocial assessment	Demographic and statistics of morbidity and mortality Chronic illness, HIV/AIDS in the community	
	Family Nursing	Provide nursing care for the family with high risks exposed to serious health problems through developmental milestones	The concept of family The role of family nurses Empowerment of the family in managing health problems	Not applicable to the contexts of caring the DDB	Idem
	Gerontology Nursing	Provide nursing care for older people through health preventive and promotion approach	Ethics and legal issues in elderly care Mental health in the old person Concept of death among older people Gerontics assessment	Sensory deprivation Loss and separation Depression and suicides Concept and responses toward death Spiritual health assessment	Idem
	Comprehensive Clinical Skills Analysis (CCSA) 2	Perform various necessary nursing skills following the ethical principles that attached to block systems under the supervision	Therapeutic communication Nursing assessment and intervention towards clinical problems: Oxygenation problems Fluids and electrolytes imbalance Nutrition Elimination Mobility and activity Perception and sensory deprivation Thermoregulation, safety and comforts	Not related to the contexts of caring the DDB	Care of terminal illness learning objective
		Care for dying patients in particular clinical settings.	No relevant content is given during the pre-clinical orientation programme	This subject is delivered in the clinical and community settings	No written case reports and no specific evaluation

For each course module, DDB-related issues – whether referred to implicitly or explicitly – were identified in the curriculum documents. Different nursing components were identified under the following categories: fundamentals of nursing (FON1; FON2; FON3), religion in nursing (RELIG), personality development (PERSN), mental health nursing (MHN), community health nursing (CHN), medical surgical nursing, (MEDSUR), critical, emergency and disaster nursing (CRIT/ER/DIS), pediatric nursing (PEDR), maternity nursing (MATER), gerontology nursing (GERONT), nursing management (NURMGT), clinical exposures (CCSA 1; CCSA 2), community nursing programme (CNP), family nursing (FAMNUR) and nursing research (NURES). However, no knowledge-based or skills-based assessment criteria were found for assessing competency in understanding and addressing spiritual care needs in the undergraduate nursing curriculum.

A few concepts and theories were already included in the materials presented to students in the intended curriculum of pre-2015. For example, Kubler-Ross's dying and death trajectories (FON1), Lazarus and Folkman' coping mechanism (MHN), and Islamic spiritual care and care of the dead body (RELIG). However, other CDDB-related content found to be missing in the academic stage included: knowledge and philosophy of DDB and EoLC, clinical and symptom management at EoL, ethical and legal issues, breaking bad news, advance care planning, care of the bereaved family, and contextual issues in EoLC practice. In contrast, these contents are accommodated in the new curriculum of post-2015 (see table 17). Concerning the affective component of course delivery, students and nurse educators reported that personality development – specifically, the personal competence needed in caring for people at the end of life – was covered only in the first year (i.e. ‘PERSN’). However, concepts and theories relating to bereavement care were not clearly described either in the pre- or post-2015 curriculum.

6.3.3 The received curriculum

The received curriculum refers to the way in which the curriculum is experienced or perceived by students during the learning process, and the learning results or outcomes of this (Kern et al., 2009; Van Zyl, 2019). Interview findings revealed that care of the dying and after-death care were viewed as informal learning objectives, but almost all students experienced learning in this area during their clinical placements. Students tended to develop autonomous and independent learning in this regard, since standardised teaching and learning experiences were not provided by the faculty or by clinical instructors. Furthermore, nurse educators guided the students based on their own personal experiences and tacit knowledge, leading to an unstandardised clinical learning experience. Such practices represent a ‘hidden’ and ‘null’ curriculum, since the skills included in the intended curriculum were not actually taught. This may lead to

unclear direction and expectations for students and teachers (Giroux, 1998; Johnson, 2009; Jennings, 2017). For example, some students reported handling dead bodies during their clinical placements (i.e. 'CCSA'), without the benefit of formal guidelines or skilled preparation during the academic stage.

Dying- and death-related issues have commonly been found to be attached to the subject of religion and spirituality in healthcare higher education (Attig, 2015). Indeed, in the nursing faculty studied here, care of the dying, after-death and spiritual care were all embedded in the subject area of 'religion' (FoN Unpad, 2015). It should be noted here that the subject of 'religion' is a compulsory course, offered to first-year students across faculties, which follows faculty policy in terms of its content and delivery methods (FoN Unpad, 2010). The subject covers the meaning of life, dying, and death, and its rituals, across cultural and spiritual backgrounds. However, there is a lack of guidance on delivering dying- and death-related teaching while embracing cultural and religious diversity. Thus, an exclusive delivery may challenge others with differing religious backgrounds. The diversity of cultural and religious backgrounds are fundamental aspects when dealing with dying and death, which should be embedded in the nursing curriculum.

6.3.4 Comparison of pre- and post-2015 curricula

As discussed in Chapter 1, PEoLC was introduced as a formal subject in the new (post-2015) undergraduate nursing curriculum. This subject is delivered in the pre-clinical learning programme under the label of 'Palliative and end of life care' (with three credits awarded in the third year) and in the clinical learning programme under the label of 'Palliative care' (with two credits awarded in the fifth year). Based on the findings, PEoLCE and PC were used interchangeably in the new curriculum, and there may be an inadequate inclusion and distribution of content across the pre-clinical and clinical phases of the learning programme.

From the results of the curriculum review, differences were also noted with regard to how the planned curriculum was delivered and taught by nurse educators. From the viewpoint of participants in this study, some skills were not taught or were found to be lacking (see section 5.2.1). There were limited insights into the scope of practice of CDDB, and an absence of EoLC as a formal subject in the 2010-2015 curriculum.

Areas of additional related content include ethical and legal issues, communication and breaking bad news, pain management, and complementary therapy. Spiritual care and care of the dead body are embedded in the subject of 'religion' (i.e. Islamic religion), without reference to related clinical laboratory skills. In the clinical learning phase, palliative care practice is further delivered in the hospital setting (amounting to 15 hours over two weeks). However, end of life care is not mentioned specifically in clinical

learning guidelines. In terms of methods of delivery, didactic teaching, active learning and experiential learning have been utilised in pre-clinical learning, such as via small group discussions, problem-based learning and simulation based learning. These methodologies were confirmed by students and nurse educators during interviews (see section 5.5.2 and 5.5.3). The delivered and received content within the new curriculum have not yet been evaluated, since this is beyond the scope of this study. Thus, the evaluation presented here provides an overview of the curriculum in CDDB, but has limitations in providing a detailed description of all CDDB-related issues covered across all teaching.

6.4 Findings of focus group discussion with key participants

This section reports the findings from the focus group discussion, which involved eight key participants (EP). This aimed to triangulate the findings of the faculty curriculum document review and thus to identify the suggested core elements of the curriculum in relation to CDDB. Triangulation of findings from the interview datasets is also reported in the overall study findings.

Three major themes emerged from the data analysis: enabling key competencies, promoting supportive and facilitative learning, and negotiating curriculum content and pedagogy practice (see Table 21).

Table 21 Themes and subthemes of focus group discussion

Theme	Subthemes
Enabling key competencies to improve learning and practice	Knowledge for practice Communication and interpersonal skills Clinical practice skills Professionalism Cultural and spiritual awareness Intrapersonal skills
Promoting supportive and facilitative learning	Engagement in teaching and practicing Resource and access provision
Negotiating pedagogy and teaching practice	Content negotiation Experiential-based learning Authenticity in practice Outcome evaluation Collaboration and partnerships

6.4.1 Enabling key competencies to improve learning and practice

Participants discussed the importance of key and enabling competencies as the foundation of professional and meaningful practice in CDDB. They reported that personal and professional attributes of CDDB should include the inter-related components of knowledge, attitudes, skills and values. These findings thus confirmed those from the interview studies.

The six key competency domains that emerged from the focus group discussion are discussed in turn below.

6.4.1.1 Knowledge for practice

This subtheme confirmed multiple ways of knowing as the foundation of planning and delivering interventions for dying patients and their families. Participants agreed that student nurses must have extensive knowledge, covering physical, psychological, social, cultural and spiritual aspects relating to dying patients and their families. Furthermore, participants agreed that students need to learn how to recognise the signs and symptoms of dying and death. For this purpose, they should learn relevant subjects, such as the basic physiology of illness, the dying and death trajectory, behavioural sciences, understanding of culture and religion, and palliative care concepts and philosophy. The physician participant in the focus group further emphasised the need for health professionals to understand current healthcare policy and practice guidelines in relation to palliative care and EoLC, since these can help prevent patients from being given unnecessary interventions which can prolong suffering.

> *(...) That is why our palliative care team often sends the patient home (…) so, within palliative care, there is a chance for the patient to die with dignity (…) There is no pressure to discharge the patient home (…) our BPJS (national insurance) will not cover it if there is an unreasonable decision of patient discharged (...)* (EP-07)

6.4.1.2 Communication and interpersonal skills

It is widely accepted that communication plays a critical role in the successful relationship between a nurse and a client, especially in the context of caring for patients and their families at the end of life. One participant said that the current undergraduate curriculum contained topics relating to communication in the healthcare context, but that the faculty needed to improve their pedagogy strategies by linking the theory and practice of communication with palliative care implementation in actual healthcare settings.

> *Communication has been put into the curriculum, but I think we need to focus on its application to the palliative care patients (…) we need to choose what theories can be applied well, so that they can fit to what the patients need* (EP-02)

Nevertheless, nurse educators and clinician participants felt reluctant to initiate discussions about death with end of life patients and their families in the clinical setting, and often feared rejection if they did so. Based on previous field observations, a non-healthcare professional participant from an NGO said that the majority of nurses were ill-prepared for talking about death with patients, which she felt was due to feelings of discomfort and lack of acceptance of dying and death issues.

> *The nurses need to admit and be comfortable with the fact that they will also die someday, because without their acceptance, the nurses will not be able to handle the patients or the families during the discussion or counselling sessions (…)* (EP-03)

Given that nurses are expected to engage in discussions about the end of life and care preferences for this phase with dying patients and their families, one participant suggested avoiding using unclear terminology such as 'getting weaker' or 'getting worse' to indicate that death is approaching. These words imply an ambiguity or uncertainty that can give patients and their families false hopes and unrealistic expectations. Hence, it is recommended that health professionals maintain openness and honesty when discussing a patient's likely future condition. However, being honest can be difficult when facing a family who are in denial of death. Nurses must therefore assess the readiness of patients and their families, providing adequate information, finding the right time to talk, and using appropriate words and relevant non-verbal cues to deliver such information to patients and families.

> *We try to avoid words like 'getting worse' or 'getting weaker' to tell the family what might happen. We have to say the word 'dead; to make it clear, and it feels incomplete when we have not said the words. At first, I was afraid that it might hurt their feelings, but the words do not make it worse because sometimes their conditions are not changeable or treatable (…)* (EP-06)

Scenarios such as these require nurses to demonstrate courage and self-confidence in initiating discussions, rather than relying only on end of life assessment and communication skills. The same participant believed that an EoLC discussion could help the family to be aware of and to prepare for future planning and arrangements:

> *(…) I have done it a few times since I finished my training; thus, I did not find a family was angry because I talked about death with them. They were happy because I opened the conversation, since the thought was kept in their heads for a while without knowing how and to whom they could talk (…)* (EP-06)

Another participant noted that, during the bereavement period, nurses cannot reduce sadness just by talking and giving encouraging words, but that they needed to demonstrate effective communication with the bereaved family. Participants also stressed the importance of the ability to listen actively and to demonstrate non-judgemental attitudes in order to build meaningful relationships with family members.

6.4.1.3 Clinical practice skills

Palliative care practitioners reported problems relating to lack of knowledge and skills among doctors and nurses in providing end of life assessment in hospitals, which can hinder the process of reviewing case findings and making appropriate referrals. In a similar vein, a community nurse practitioner commented that assessing the dying patient at home can be different from in the hospital. She further suggested that nurses need to demonstrate their independent capacity and courage to make decisions for dying patients, without supervision from other health professionals and/or advanced health technology supports.

> *For the home care nurses, the main thing about their courage is when they need to make an independent decision and then do the actions as needed (…) nurses have automatic alarm systems in the hospital, but it is entirely different when they are in the community setting, particularly at the patient's house (…)* (EP-04)

This participant suggested that students should understand current assessment tools for identifying the needs of dying patients and their family caregivers. Using an example of an approach used in her own institution, the participant described how students learn about cancer case management, and how to conduct patient assessments, by following a compulsory learning programme in community settings.

> *In our place, we share clinical symptoms often found and then try to manage them (the patients) we sent the students doing a field trip to the YKI's office (Indonesian Cancer Foundation) (…) they visited the community hospitals to see the critical illness patients and then they reviewed what they learnt about them (…)* (EP-01)

Pain management was considered a major constraint in community settings, with often limited access to pain relief. This echoed the findings from the interviews with students and nurse educators. Factors such as these can impact on the quality of services delivered to patients at the end of life and their families. Participants agreed that this situation necessitated intense collaboration between the palliative care team in the hospital and those in charge of community healthcare. Nonetheless, inadequate referral systems and a lack of trained health personnel with palliative care and EoLC skills and experience, both in the clinic and community settings, could often inhibit such collaboration.

> *(…) It is still challenging to get the prescription of the needed medicines in the apothecaries around. We still need to go to the hospitals to get them. That is a problem for us in the community hospitals, because we need to go all the way to the hospital when we need the medicines (…)* (EP-04)

Participants emphasised four important aspects in dealing with last offices and bereavement care: maintaining dignity and respect for the dead body, preparing the ward environment, allocating private time for the family to be with the deceased, and

preparing for transfer of the dead body. Regarding care of the dead body, most participants confirmed that nurses usually cleaned and prepared the body in the ward prior to transfer to the mortuary unit. Participants agreed that nurses should be able to explore the family's needs and expectations when death occurs and during the after-death phase. Nurses also needed to facilitate families' decisions on how the deceased body should be managed, and demonstrate respect towards the dead body by treating it gently and respectfully.

> *(…) We need to act correctly when a patient dies. We need to show respect to them and see if we can take care of the corpse properly (…)* (EP-05)

Overall, it appeared that bereavement care does not exist within Indonesian hospital settings, and that families do not have sufficient support during the mourning period. Whilst participants said that the extended family played a significant role in providing bereavement support in community settings, they nonetheless agreed that bereavement care needed to be properly incorporated into the current learning programme.

6.4.1.4 Professionalism

Professionalism constitutes the conduct or qualities that characterise a nurse when performing her/his professional duties (Jayasekara, 2008). This theme further reflects individual aspects that relate to the attitudes and behaviours adopted in responding to dying patients and their families. Four components were identified from analysis of the data from the focus group discussion: ethics and values, critical thinking and decision-making, leadership and clinical management, and interdisciplinary teamwork.

When dealing with people at the end of life, nurses need to shift from a biomedical orientation, with a task-based approach, to a more humanistic and holistic approach. Most participants agreed that personal knowledge, beliefs, and values about death and dying influenced the ways in which nurses provide care for patients and families. Knowing the needs and preferences of the patient and family is important when making any clinical decisions. This reflects personal awareness of the importance of patient-focused and family-centred care in clinical settings. Furthermore, nurses need to improve their ability to empathise and show compassion through their communication and interactions with dying patients.

> *The nurse needs to give the nursing care with compassion, so that the patient feels better even from the nurse's touch. The nurses need to have that using their gaze, eye contact, and touch, but they must be right (…)* (EP-01)

Another participant said that nurses needed to be able to establish professional relationships with patients and their families, in order to successfully achieve the goals of care and provide appropriate interventions.

> *(…) The nurses sometimes only see a new patient admission as only a routine. This mindset needs to be changed, because nurses need to have the ability to become partners and act as a bridge for the patients and the families to be ready for anything (…)* (EP-04)

Key participants mentioned that being a good care provider and an advocate for patients and families is the most relevant role of nurses. However, nurses often relied on their *ad hoc* judgments when making clinical decisions, due to lack of knowledge, professional autonomy, and/or organisational support. These comments from key participants further confirmed the need identified by nurse educators in the interview study for nurses to be empowered by following continuing EoLC education and in-service training in their institutions (see section 5.4.3).

Participants further described nurses' roles and responsibilities in CDDB within hospital settings. One palliative care nurse shared her experience of dealing with tensions between family members and health professionals owing to differing expectations. For example, in one instance, family members had put pressure on doctors to maintain life-supporting devices and give aggressive treatments, despite the fact that the patient would not gain any benefit from such interventions.

> *I think it is essential for the nurses to be able to facilitate the patients' wishes so that the patients' beliefs and customs can live on. The other important function is to be an advocate when the patient's wish is not in line with what the family wants. The nurse's functions as an advocate and a facilitator are similarly essential (...)* (EP-01)

Participants agreed that nurses need to have adequate knowledge about the principles of ethical and legal issues in EoLC, so that they could recognise any problems or instances of misconduct. One participant also suggested that nurses need to know how to assess the capacity of patients and family members to make decisions.

> *(…) When the family agrees to stop the life support, we assigned, AND (Allowed Natural Death), so the family will not be surprised. However, some of them are not ready to make the decision (…)* (EP-04)

The above participant added that families of dying patients in Indonesian culture have a strong influence during the decision-making process about care regimens and the best place to die. She had noticed that many families preferred the patient to be hospitalised until they died, due to lack of capacity to provide EoLC at home. This situation requires nurses to make a further assessment of family circumstances.

> *Some of the family usually start to gather and pray for the patient. Some of them do not know what to do at home, so they choose to stay in the hospital, but they will not take any actions that may put the patient in pain for a longer time. There is a paradigm shift, but once again we need to know how to communicate it with the family (…)* (EP-04)

To reduce power struggles between patients and health practitioners due to differing expectations, one key participant suggested that students and nurses should be introduced to the critical issue of understanding informed consent and how to obtain such consent before decisions are taken. In contrast to western individualist laws and customs, Indonesian family members are allowed to provide informed consent on behalf of an unconscious dying patient.

> *(…) When the family agrees to stop the life support, we assigned AND so the family will not be sure. However, some of them are not ready to make the decision (…)* (EP-04)

> *If the patient cannot communicate well, then we can ask for the family's wish. The flow is arranged and given of the inform consent has its arrangement. We need to make sure that we ask the family members or relatives first before asking other family members, even a small child (…)* (EP-07)

This situation requires nurses to understand advance care planning and how to educate families in this regard. However, this concept is not well understood by most health professionals in Indonesia (as reported in chapter 1), resulting in an urgent need to incorporate this into the healthcare curriculum. One palliative care nurse educator commented on this issue as follows:

> *(…) Advance care planning, and it is gaining popularity abroad. It is when the patient's wishes are written in advance when they are admitted in the hospital (…) I think this practice may be available in some hospitals here, but it is not the standard yet, so maybe we can start putting it in training in the academy (…)* (EP-01).

Additionally, power imbalances are a potentially important issue when building relationships with dying patients and their families. Clinical leadership and management capacity are crucial for nurses working in the EoLC area.

> *(…) Within the hospital's environment, the nurses will have more power, but in the family's house, the nurses will have less power because they might think that they are only visitors, so they are not always doing what they should do (…)* (EP-05)

Interdisciplinary teamwork in EoLC was one of the most discussed topics among participants. The importance was stressed of having good care coordination and shared responsibilities between families and healthcare professionals when caring for dying patients in hospital. For this purpose, creating a culture of equality among team members is essential when caring for dying patients, as alluded to by one physician:

> *(…) we need to have skills to become a collaborating facilitator, as everyone in the team is equally important* (EP-07)

Therefore, being knowledgeable about palliative care and EoLC, understanding roles and responsibilities, having effective communication skills, and interprofessional collaborative practice are all critical aspects in this area.

6.4.1.5 Cultural and spiritual awareness

Participants stressed the importance of learning to care for dying and dead patients within different cultural and religious contexts. Nurses are expected to be able to recognise patients' spiritual needs and those of their families, particularly in the clinical setting. Hence, participants agreed that nurses need to facilitate the provision of spiritual care regardless of different ethical viewpoints, faiths or religions. Furthermore, one palliative care educator participant suggested that nurses need to identify the spiritual and religious needs of patients and families, as an essential aspect of promoting dignity in dying and death.

> *(…) We might find different rituals from different religious or racial backgrounds of the patients (…) it is important for students to know whom to talk to or whom to consult with when they need to take care of a non-Muslim patient. I think some of the patients' last wishes are culture-related as well. Like there is a custom of a tribe who needs to cry out loud when mourning one of the family members who pass away (…)* (EP-01)

In contrast, clinician participants mentioned that their limitations in providing spiritual guidance had often prevented them from meeting patients' spiritual needs and necessitated their liaising with spiritual care teams in the hospital. One participant (EP-02) said that having a basic understanding of how to provide spiritual guidance could enable nurses to support dying patients should their families be absent or chaplains be unavailable in the hospital. Similarly, a community nurse participant noted that families generally wished to involve a clergyman or spiritual leader as the ultimate person to provide spiritual guidance for a dying patient at home. Hence, nurses need to be aware of their professional roles and boundaries in delivering spiritual aspects of EoLC in home settings.

Participants agreed that patient-focused, family-centred care (Teno et al., 2001) is considered the best approach for CDDB. Whilst Indonesian culture emphasises collective decision-making by the extended family, the patient's preferences should nonetheless be prioritised, including when the family might disagree on a particular issue. One palliative nurse reported her experience of communicating a patient's final wishes for a different method of funeral from that which was traditional in his family:

> *We had a case of a Korean who converted to Islam, and he wished to be handled like a Muslim after his death, but he wished to be cremated instead of buried. This is one of the occasions when we need to respect the patient's wish. As a Muslim, we know that it is not a Muslim way to have the dead body cremated, but we cannot tell the patient that he or she is wrong. We need to believe that what the patient chooses to do is beyond our responsibility. Thus, we only need to facilitate the patient and make sure that*

> *the patient gets what he or she wishes for (…) We need to include that kind of learning experience so that the student will be ready to face such problems in the real practice (…)* (EP-02)

6.4.1.6 Intrapersonal skills

This subtheme reflects the impact of dealing with dying and death during clinical learning placements, and the challenges this poses to participants' ways of thinking and behaving towards dying patients. Three important aspects were highlighted: knowing self and others, readiness to practice, and self-care. Participants agreed that nurses needed to learn about psychological aspects of care, so that they could recognise the needs of dying patients and their families and identify the best ways of meeting these needs.

> *The nurse needs to prepare the patient's needs and then make sure the family will understand. That is why the nurse needs to have basic psychological knowledge so that they will understand what the patient wants when they still can communicate well (…)* (EP-07)

Participants pointed out that students and nurses needed to cultivate non-judgmental attitudes towards patients' wishes, without reference to their own attitudes or preferences. However, nurses often used their own beliefs and norms as a lens by which to understand and respond to existential issues. This could result in their disengaging when providing care, and/or being less sensitive in recognising the distress of some patients and families. Nurses therefore need to remain aware of personal and professional boundaries at all times.

> *Another important thing is the ability to understand the patients' feelings and also the feelings of the patients' family members. I am saying this because, from my experience, the nurses often get carried by their feelings when seeing death. Consequently, they cannot give appropriate care to the patients or their family members when they need it the most (…)* (EP-03)

Participants also agreed that recognising their own feelings and acceptance, or otherwise, of dying and death is important when caring for people at the end of life. Dealing with patients' suffering for extended periods can lead nurses to become emotionally exhausted, and thus their empathy towards dying patients can decline. Hence, participants suggested that nurses should engage in self-reflection before and after managing a dying patient, so that they might identify any personal issues and seek further help if these persisted.

> *The nurses need to admit and be comfortable with the fact that they will also die someday, because without having an acceptance, they will not be able to handle the patients or the families during the discussion or counselling sessions* (EP-03)

Caring for dying patients can take place within diverse settings, which can challenge students' preparedness and readiness to practice, as described by the following nurse practitioner participant:

> *Our nurses have not possessed this feeling of being responsible, because they tend to focus on physical care. They have not touched the patients' feelings or even the family's feelings. This requires extra preparation from the students, as they need to be ready to deal with the dying patient and the family, either in the hospital or at home (…)* (EP-04)

One physician participant suggested that, since not all healthcare practitioners could be equally well-adjusted when dealing with complicated situations, the nursing faculty should conduct a screening programme for students before entering the nursing programme in order to assess students' readiness for clinical practice. However, another participant from the association of nursing education argued that such selection would be disadvantageous in terms of diversity of talent, as well as the principles of equity and justice, since all students should have the right to fair educational opportunities.

> *(…) Screening the nursing student candidate using assessment tools before entering the university against the right to receive public education services thus negates the equity and justice principles (…) Nevertheless, conducting training needs assessment seems possible to identify those who would enter specialist training (…)* (EP-08)

Participants further supported the idea that nurses needed to focus on their own self-care, and thus maintain emotional equilibrium, when encountering adverse impacts of dealing with dying and death in their daily practice. Several means of doing this were suggested, including engaging with music, arts, or other programmes of relaxation. One participant added that debriefing activities during clinical supervision and mentoring could help, as well as sharing feelings with friends, using peer support groups, strengthening individual religious activities, and conducting reflective practices.

In summary, all participants agreed that promoting CDDB in clinical practice should be developed following the domains of competence and enabling key competencies, as shown in Table 22 below.

Table 22 Identified key and enabling competencies from focus group findings

Key competency	Enabling competency
Knowledge for practice	Scientific theory and evidence-based practice (physical, psychological, social, cultural and spiritual aspects of dying, death and bereavement), ethical and legal issues, roles and responsibilities
Communication and interpersonal skills	Effective communication, listening actively, non-judgemental attitudes, openness and honesty, courage and confidence
Clinical practice skills	Assessment of dying and death, pain management, necessary nursing skills, care of the dead body, bereavement care
Professionalism	Ethics and values, critical thinking and decision-making, leadership and clinical management, interprofessional teamwork
Intrapersonal skills	Knowing self and others, readiness to practice, self-care
Cultural and spiritual care	Cultural awareness, spiritual well-being, patient-focused and family-centred care

6.4.2 Promoting supportive and facilitative learning

This theme arose from the discussion surrounding the urgency of personal and professional development in promoting CDDB, both in academic and clinical contexts. A facilitative environment refers to one in which the educational atmosphere and facilities support the personal and professional development of learners (Poultney et al., 2014). Both physical and non-physical environments can influence well-being, learning and functioning. In this study, participants agreed that providing formal and informal support for students and nurses can contribute towards enabling their professional capacity in CDDB. Promoting support and facilitation was further highlighted as part of problem-solving toolkits to encounter the adverse effects of CDDB.

6.4.2.1 Engagement in teaching and practice

Professionalisation of nursing, which is concerned with the development of the professional nurse identity within a wider health professional community, was highlighted in the focus group discussion. Key participants shared their concerns about nurse educators' failure to maintain clinical engagement due to the 'dual world perspectives' that arose from the professionalisation of nursing. Such a culture can result in a lack of clear roles and responsibilities on the part of nurse practitioners and nurse educators. As previously alluded to in the interviews with nurse educators (see section 5.4.2), clinical duties are not considered part of the formal workload of nursing

faculty members, and vice versa. Such a policy might thus hinder the improvement of professional competencies.

> *It is difficult to standardise a lecturer's clinical performance grading method within the current working system (…) due to a 'dual policy'; that is, a lecturer is not a nurse practitioner, and a nurse practitioner is not a lecturer (…)* (EP-08)

6.4.2.2 Resource and access provision

Participants alluded to different working systems, lack of practice standards, and inadequate clinical experiences as barriers to faculty members or clinical instructors becoming good role models for students. Furthermore, one key participant reported limitations in the provision of teaching and learning resources, access to relevant teaching and learning materials, and clinical placement settings. This led to discrepancies in the implementation of the national curriculum across regions.

> *(…) nursing academy faces challenges with limited feasible and affordable clinical learning sites, since most hospitals asked for clinical practicum payments (…) dissimilar standards of healthcare delivery services and the quality of human resources (…)* (EP-08)

Key participants from professional nursing organisations suggested that large teaching hospitals could be the most suitable settings to accommodate clinical placements, and create personal and professional development programmes for students, practitioners and educators.

6.4.3 Negotiating pedagogy and teaching practice

This theme emphasised the importance of process integration, negotiation and collaboration in revising the existing curriculum and refining the established course content relating to CDDB. Five elements reflected current pedagogical and practice issues related to CDDB: content negotiation, experiential-based learning, authenticity in practice, outcome evaluation, and collaboration and partnerships.

6.4.3.1 Content negotiation

In the focus group discussion, two key participants from the Association of Nursing Education and Practice pointed out the absence of core competencies in clinical teaching and supervision focused on caring for people at the end of life. In response, one key participant recommended the development of core competencies for nurses covering knowledge, skills and attitudes needed for CDDB. A clear description of core competencies could guide curriculum developers in developing content following the level of nurses' skills acquisition (i.e. generalist and specialist). Nurse educators could therefore quickly identify the breadth and depth of materials needed to be presented to students or nurses, as well as how to teach and evaluate the delivered contents.

> *(…) lack of competencies in teaching and supervising students (…)* (EP-08)

> *(…) we can decide the modules of the teaching and set up the competency's levels for generalist or specialist (…)* (EP-02).

Furthermore, the curriculum content should be developed based on the needs and expectations of users. Needs assessment may assist faculty administrators in developing relevant curriculum content and educational interventions (Kern et al., 2009). Most participants agreed on the importance of situational analysis to explore patients' needs prior to developing competencies and designing the curriculum. The results of such assessments would thus help administrators to create learning modules that were also relevant to the needs of patients and families.

> *(…) we need to identify what the palliative patients need (…) when we know what they need; we will be able to increase the effectiveness of our care (...)* (EP-02)

As discussed in Chapter 2, EoLC has become a global issue that should be paid due attention by practitioners, academics and policymakers. Discussion surrounding this area was found to be lacking in the current Indonesian healthcare education and practice agenda, as described in Chapters 1 and 2. Hence, two key participants from the nursing professional organisations suggested that the faculty of nursing needed to improve its curriculum and pedagogy practice. To support this, reconceptualising the curriculum orientation is necessary. This reflects the current need to advance the nursing curriculum and enhance its quality in order to meet global standards.

6.4.3.2 Experiential-based learning

Focus group participants agreed that active learning and experiential-based learning were ideal approaches in nursing education. They recommended using role play and simulation-based learning to learn about assessment of dying patients, communication with dying patients and their families, facing negative responses from patients, families and/or other practitioners, and care of the dead body.

One of key participants suggested a comprehensive method to evaluate knowledge, attitudes and skills components:

> *We often do role play, and (…) OSCE for complicated cases (…) breaking bad news, diagnosis, or bad prognosis (...) stating the signs of dying (…) patients with denial or anger (…) the exercises are essential, and the students should be given descriptions of what the stages are and how to say things that are difficult to describe (…) It is a bedside teaching (…)* (EP-06)

A further essential feature of the proposed curriculum is an overall balance between theoretical and practical components, which needs to be maintained throughout the educational process. Participants debated ideas surrounding separation versus

integration of learning content, and highlighted current incongruences in classroom-based and clinical-based learning. They suggested that the integration of learning about dying and death could be facilitated in the undergraduate period through the inclusion of pre-clinical and clinical stages as one continuum in teaching and learning. This integration could use either a 'vertical' or a 'horizontal' approach, from the foundation years to the final year of study (Prideaux, 2010; Miller, 2011). Participants believed that such integration efforts could facilitate students' learning retention and thus contribute to the development of their competencies and confidence.

6.4.3.3 Authenticity in practice

Authenticity in practice relates to internal factors that influence the caregiving process and professional relationships among patients, families, students, teachers and professionals. Two components were identified that contribute to the development of authenticity in practice when providing CDDB: personal resources, and personal and professional boundaries.

In establishing a good nurse-patient relationship, nurses are expected to develop positive characteristics that enable them to cope with issues of dying and death. EoLC delivery is a unique, complex and often challenging area, and differs fundamentally from normal clinical care when handling acute or chronically ill patients. Having suitable personal resources that allow maintenance of positive attitudes is therefore essential. Indeed, the personal characteristics required reflect the types of services being delivered, including empathy, resilience, creativity, the ability to think 'outside the box', and courage.

> *For the nurses, the main thing about their courage is when they should make an independent decision and then execute it (…)* (EP-05).

These aspects require advanced skills that have a basis in both relevant theory and practical elements in the curriculum.

> *(…) resilience (…) must be driven by their hearts (…) have passions to take it (…) they should be a peculiar people (…) and able to think 'out of the box'* (EP-07).

One key participant warned that power imbalances might occur when building relationships with patients and families, particularly in home care settings. To reduce such problems, nurses needed to develop and maintain their professionalism. Furthermore, establishing personal and professional boundaries is essential in preventing nurses from being emotionally exhausted, which can lead to uncompassionate behaviours towards patients (Edo-Gual et al., 2015). In this study, professional boundaries are conceptualised as nurses' ability to stay focused on the achievement of goals and care objectives within caregiving relationships, allowing nurses to adopt a genuine, trustworthy and professional approach.

6.4.3.4 Outcome evaluation

The findings of the focus group discussion elucidated issues relating to intended learning outcomes, and evaluation of these using comprehensive assessment methods. Participants from the nursing association and clinical practice agreed that the evaluation of learning should focus not only on knowledge components but also on attitudinal and skills aspects. One participant pointed out the importance of critical reflection in evaluating the process and results of teaching and learning activities:

> *I do not agree if the cognitive is higher than other aspects, because we should also be concerned about the reflection of the nurse (…)* (EP-05)

6.4.3.5 Collaboration and partnerships

Caring for dying patients and their families requires health professionals to formulate goals of care based on patients' needs and preferences. However, such plans cannot work in practice if team members do not share mutual respect towards each others' professional expertise. One participant emphasised the importance of healthcare professionals' readiness for inter-professional collaborative practice in EoLC.

> *(…) Regarding collaboration, I agree that other professions' readiness must support the nurses' readiness. The doctors must be the first to get ready to acknowledge the needs and then provide palliative care. After the doctors, other professions can follow (…)* (EP-04)

One palliative care physician participant warned that medical dominance and a lack of professional autonomy could prevent effective interprofessional collaborative practice in hospital-based EoLC. This confirmed the findings from interviews with nurse educators, in which the biomedical hegemony was felt to create discrepancies in communication patterns and contribute to delays in decision-making processes (see section 5.3.3).

In addressing this situation, the above palliative care physician recommended that nurses should enhance their professional knowledge and skills in caring for dying patients and their families. She suggested that an interdisciplinary approach to teaching and learning was an imperative agenda in teaching nursing students about dying and death. Through this approach, students could thus learn about care coordination and the shared responsibilities of families and healthcare professionals, both in the hospital and following discharge.

Another key participant from the Association of Nursing Education suggested that expanding collaboration between academics and practice settings is necessary to improve learning resources and provision of supportive learning environments for students.

The integration of nursing practice and education can be facilitated through the establishment of a university teaching hospital (…) (EP-08)

In summary, the focus group interviews with key participants highlighted key barriers and facilitators relating to CDDB in clinical and community settings, and echoed the findings from the interviews carried out with students and nurse educators. Recommendations were made to address the issues identified, with further elaboration regarding developing key and enabling competencies (process and outcomes), curriculum and pedagogical negotiation (integration and collaboration), and support and facilitation (empowerment), as described in Table 23 below.

Table 23 Core elements generated from the reviewed curriculum document of pre-2015 and focus group discussion

Core element	Source	
	Curriculum document review	**Focus group discussion**
Content	Palliative and end-of-life care Communication Ethical and legal issues Cultural diversity Spirituality and religiosity Patient-centred care Patient safety Personality development Interprofessional collaboration	Knowledge for practice Communication and relational skills Professionalism: ethics and values, critical thinking and decision making, interdisciplinary teamwork Cultural and spiritual care Coping skills Clinical practice skills: care of the dead body, bereavement care
Outcomes	Knowledge Attitudes Skills	Knowledge Attitudes Skills Values
Context	Classroom Clinical practice Community settings	Classroom Clinical practice Community settings
Pedagogy	Lecture Seminar Small group discussion Role play simulation Online learning Blended learning Skills laboratory practice Clinical practice Written test SOCA OSCE DOPS	Lecture Seminar Workshop Role play Simulation learning Skills laboratory practice Interdisciplinary approach Clinical practice Community fieldwork Written test OSCE Reflective practice
Empowerment	Journal access Textbooks Learning modules	Collaboration and partnerships Clinical mentoring and supervision Continuing education and training Learning modules Journal access Textbooks Practice guidelines

6.5 Discussion and conclusion

CDDB is not clearly defined in the intended curriculum of either pre- or post-2015, nor is this subject thematically presented in the taught curriculum. Instead, CDDB training is present but hidden, integrated in an unstructured way, and perceived differently by nurse educators and students. It is unclear whether students graduated from the nursing faculty with adequate skills and knowledge for caring for patients prior to and following death.

This study confirms that CDDB is a hidden subject in undergraduate nursing curricula (Mallory, 2003; Ferrell et al., 2005; Johnson, 2009; Condon et al., 2013). Previous authors have highlighted the need for articulation and evaluation of areas such as communication skills, cultural and spiritual competence, professionalism, and ethical and legal aspects in the nursing curriculum (Allchin, 2006; Johnson, 2009; Nieddrieter, 2009; Muhto et al., 2010; Ek et al., 2013; Parry et al., 2011; Adesina et al., 2014; Park et al., 2014). It may be that CDDB-related topics are seen as outliers of scientific knowledge and of the biomedical orientation. That is, they are not considered 'scientific' contents, but are often viewed as 'common sense' subjects – i.e. an area that students and nurse educators already know of, or will learn about without the need for further emphasis during the undergraduate training period (Watchler et al., 2003). This perspective is problematic because viewing CDDB as personal and subjective, and thus not quantifiable, can hinder the assessment of students' skills in this area.

Findings from the curriculum document analysis demonstrated that dying and death have become formal concepts in undergraduate nursing education in Indonesia. However, teaching and learning activities are unstructured, compounded by the absence of intended learning outcomes. In responding to this situation, the findings from the focus group discussion highlighted fundamental aspects of the curriculum framework, namely, key and enabling competencies, promoting a supportive and facilitative environment, and negotiating curriculum and pedagogy practice.

The old and new intended curricula further demonstrated significant differences in content and pedagogy, which supports CBE and Student Centred Learning (SCL). In general, the new curriculum contents run parallel to those included in the global and regional EoLC curricula in relation to cultural and spiritual aspects. However, the post-2015 curriculum shows a lack of content in the areas of EoL assessment, symptom management, ethical and legal issues in CDDB, breaking bad news, care of the dead body, and bereavement care, as suggested by international organisations (ELNEC, 2015; NICE, 2014). The intended curriculum also shows less emphasis on empowerment than that suggested in the emergent findings from the focus group. There were scarcities in the areas of clinical learning practice, clinical mentoring and supervision, continuing education and training, collaboration and partnerships, learning

modules, and practice guidelines. Further attention should therefore be given to these components in future revisions of the curriculum design.

Findings from the focus group discussion and the curriculum document review suggested additional core contents that should be embedded into the CDDB curriculum in future. Five categories of elements that should be developed and improved in the curriculum were identified: content, context, outcomes, pedagogy, and empowerment. These categories could be used as basic elements of a model for developing a core curriculum of CDDB in Indonesia. A similar evaluation across multiple nursing faculties is, however, recommended in order to explore the effectiveness of the new curriculum of CDDB, to compare students from different nursing schools, and to enable further development of EoLCE. This study reveals that conducting a curriculum evaluation using a single perspective can be misleading, since it does not permit alternative interpretations or experiences of the curriculum. Using a multi-method approach would enable curriculum developers to identify inconsistencies and points of similarity between different perspectives. It would thus allow curriculum developers and researchers to ask how the current curriculum works, what are the common barriers or pitfalls, and what they might do to improve this. Whilst total congruency between different curriculum perspectives is perhaps unrealistic, it would nonetheless be possible to balance inconsistencies and to develop the curriculum to make it more flexible and practical.

Curriculum mapping has been advocated to make the curriculum more transparent to stakeholders, and to demonstrate the links between different elements of the curriculum (Harden, 2001; Kern et al., 2009). Kern et al.(2009) emphasised the importance of incorporating multiple perspectives into curriculum evaluation, and a key strength of this curriculum mapping study was the inclusion of a focus group with key participants from heterogeneous backgrounds. This enabled different perspectives to be presented, based on their diverse practical experiences, and this proved valuable in terms of critiquing the intended curriculum and providing suggestions on any overlapping or missing content. Participants were also able to give more objective feedback owing to a lack of personal interest in the process of curriculum development and implementation.

The data reported in Chapters 5 and 6 were discussed and further analysed to determine the major elements of the curriculum framework within the existing curriculum. The following chapter discusses these findings, in relation to relevant theoretical perspectives drawn from the literature.

7 Discussion

7.1 Introduction

This chapter reviews the major findings from this study and their implications and contribution to the overall body of knowledge. The research findings are interpreted in terms of how the emergent themes relate to the aims of the study, the research questions, and the theoretical perspectives presented in Chapter 2. Potential future directions are suggested for developing CDDB in nursing education, along with a pedagogical framework which attempts to integrate the findings.

7.2 Review of findings

Findings from the international scoping review indicate a need to balance current nursing education in order to emphasise interpersonal meaning-based aspects of care, as well as the traditional positivistic approach to DDB. Review of international curricula confirmed a lack of structured education relating to CDDB in undergraduate nursing programmes. Attributes and scope of practice, curriculum content and pedagogy practice, and support and facilitation become critical issues in the development and implementation of education focused on CDDB. Several components of international EoLCE are found in the Asian curricula, which less emphasis on CDDB. The major components identified for education on care of the dying, from both the global literature review and the scoping review of Asian curricula, included: competency and outcomes, curriculum and pedagogical approach, and needs of support and facilitation.

Based on the interview and focus group findings, students' and nurses' professional competencies in CDDB practice were shaped by a variety of personal, professional, organisational and environmental factors. The tendency of CDDB to become an 'intangible' area of practice and learning further challenges the development of professional attributes and scope of practice and the establishment of professional and meaningful relationships during the educational process. Additionally, lack of knowledge, skills and clinical experience influenced nurse educators' ability to transfer knowledge and guide students when dealing with dying and death. This was compounded by inadequate support and facilitation, which caused the de-prioritisation of dying and death topics in routine teaching and learning activities. Nurse educators' practices surrounding CDDB in the classroom and in clinical teaching are influenced by teaching and mentoring agency, student-teacher interaction, roles and responsibilities, reflection and engagement, professional development, and resources and access provision. Negotiating curriculum and pedagogy practice is essential to faciliate meaningful practice and learning in CDDB, which emphasised contextualisation, content negotiation, and frame of references.

Results from the pre and post 2015 faculty curriculum mapping exercise corroborated the previous findings, indicating that formal concepts relating to CDDB were not sufficiently prioritised to be properly delivered and assessed during pre-clinical and clinical learning programmes. Although dying and death content are officially included in the current curriculum, there is nonetheless a poor alignment of content, context, pedagogy and outcomes. The findings thus indicated a need for curriculum improvement, both in the pre-clinical and clinical training programmes. Some areas which enable development of key and enabling competencies for CDDB needed particular improvement. These related to knowledge for practice, communication and interpersonal skills, practice-based skills, professionalism, cultural and spiritual awareness, and intrapersonal skills. Enhancing curriculum and pedagogical strategies, and facilitating support structures, are therefore essential elements in supporting the process of curriculum reconceptualization.

Following the discussion of theoretical frameworks in Chapter 2, relevant theories were used as a lens to capture the context, pedagogy, outcomes, agency, interaction and empowerment themes identified in all datasets.

7.3 Multiple theoretical frameworks underpinning the study

As noted in Chapter 2, this study used Kern's six-step approach to curriculum design (Kern et al., 2004) as a process model that emphasised problem identification and general needs assessment (step 1), followed by targeted needs assessment (step 2). Key findings from the core study (interviews) and complementary studies (document reviews and focus group discussion) reflected social, cultural and critical educational elements that should be further elaborated before developing the curriculum. Following the results of data analysis, it was apparent that Kern's model has limitations in reflecting the social and cultural construction of CDDB. Specifically, Kern's model does not consider issues of power and hierarchy, and cultural and socio-political stuations which are evident in current CDDB practice and education. Lee et al.'s (2013) critique that the nature of technical-rational based curriculum model should be combined with relevant philosophy underpinning the curriculum and pedagogical approach. Therefore, rather than relying on a single theory, eclectic and multiple theoretical lenses may be applied to unpack the study findings (Boland, 1998).

As discussed in Chapter 2, there are a multitude of theories that may be employed to underpin EoLCE and adult learning. The use of educational theory is not static, and requires continual reflection and modification (Kim, 2017). Brendel (2007, cited in Campbell, 2017) advocated that nurses are in a unique position to validate how patients make meaning of their experiences, and to assess whether perspectives on meaning shift and perhaps even act as the triggers of such transformations. Sociocultural and transformative learning principles were used in this study as underpinning theory to

explain how the core elements of the framework may be structured within the current nursing curriculum. Sociocultural theory was used to interpret findings that focus on content, context, pedagogy, interaction, and integration in teaching and learning of CDDB. Transformative learning principles were selected to illuminate discussions about agency, power, hierarchies, and socio-political aspects in the context of CDDB in nursing education and practice. This use of the principles of sociocultural and transformative learning further reflects pragmatism as the underlining epistemology and the use of critical ontology (Forester, 2013).

7.3.1 Social transformative learning principles

Scaffolding is the process through which efforts are supported while engaging a learning or performance task (Wood et al., 1976). Scaffolding can be differentiated by mechanism and functions. Mechanism emphasise the methods through which scaffolding is provided, while functions emphasise the purpose served (Brush and Saye, 2001 cited in Goss, 2016). While scaffolding is not a stand-alone education theory, it is an important educational process that can help learners to achieve their competencies within a continuum of learning process. Where the learners are on the continuum determines how much or how little scaffolding is provided. Scaffolding is further associated with Vygotsky's zone of proximal development (ZPD), which considers children can learn about concepts through a gradual learning process that accommodates their potentials and learning needs. Such concepts thus in line with Dewey's principles of continual growth as the aim of education. Both of these principles require social and mutual interaction and supportive learning community.

Mezirow's (2009) transformative learning theory assumes that people use personal experiences as a frame of reference to shape their beliefs and actions. Transformative learning comprises the processes by which learners transform existing, taken-for-granted frames of reference (habits of mind, meaning perspectives and mindsets) to facilitate their becoming more engaged and open (e.g. via the capacity to manage emotions, handle change and self-reflect) so that they might generate beliefs and action based on evidence (Mezirow, 2000). Mezirow further states that habits of mind includes sociolinguistic, moral-ethical, learning styles, religious, psychological, health, and aesthetic. Transformative learning requires both critical self-reflection and contributing to a dialogue in a complete and unreserved manner. The reflection caused by a crisis or series of insights causes a person to reevaluate beliefs constructed from past experiences. People can realign their habits of mind in the light of present experiences. This transformation allows individuals to expand their understanding of the world. Mezirow further adopts the elements of critical theory of Habermas (1976) and Dewey's (1981) pragmatist perspective in which communicative learning and instrumental learning are important components of the transformative learning process. Adults achieve communicative learning through knowledgeable dialogue, which creates

defensible beliefs. They achieve instrumental learning when they use evidence-based research to arrive at the truth.

7.3.2 Pattern of knowing in nursing

Findings indicate that dying and death is a hidden curriculum (see section 5.3), which needs to be deconstructed through the application of nursing ontology and epistemology. Pattern of knowing, which represents multiple ways of knowing in nursing, may be used as a theoretical lens of transformative learning of CDDB (Smith-Stoner, 2011). McGovern et al. (2013) suggest that Carper's four ways of knowing supports the nurse educators' capacity as facilitators to frame case scenarios, learning objectives and debriefing. They found that ways of knowing have prevented students and nurse educators from being 'preoccupied with psychomotor tasks and objective assessment skills' (p. 49). Smith-Stoner (2011) highlighted the urgency of emancipatory knowing to develop reflective practice as an evalution method of dying, dead and death educaton for pre-registration students and nurses. Findings suggest that holistic education may be considered an ultimate approach that integrates praxis for changing the nature of the person and focus of nursing as the united dimension (see sections 5.5 and 6.4.3). Thus, Kim (2017) offers the utilisation of praxis (following Schon (1987) and Freire (1991)) as the primary aspect that links critical reflection instead of critical thinking, and thoughtful reflection and actions in shaping better provision of EoLC. Such emancipatory knowledge is needed for the development and implementation of a holistic and humanistic CDDB. Hence, multiple ways of knowing is used in the present study to help interpret content and pedagogy relevant to CDDB.

7.3.3 Novice-to-expert theory

Findings reveal that students and nurses are expected to develop professional attributes and skills for practice of CDDB following different levels of competency (see sections 5.2 and 6.3.1). Following Benner (1982), as cited in Pope (2013), novice nurses often rely on written information and practice standards to provide EoLC to patients and their families. An advanced-beginner nurse already has some experience, however, such nurses still need mentoring and guidance focused on the global aspects of EoLC. Benner (1982) states that a competent nurse has attained certain goals to provide efficiency and mastery in EoLC. The proficient nurse often uses their perceptions and a holistic approach when responding to situations and providing EoLC. An expert nurse does not rely on rules, and can act appropriately by integrating their intuition into real-life practice (Benner, 1982). In essence, nurses reach their competence level when they are able to make the connection between the didactic information and clinical experience in EoLC (Galloway, 2009). Despite criticism that it lacks a clear direction and real outcomes, Benner's theory is used to guide curriculum development. For example, in simulation learning for undergraduate nursing students (Traynor, 2010;

Lippe et al., 2015; Thomas et al., 2017) and in faculty development (Waxman and Telles, 2009).

7.4 Discussion of major findings

This section discusses the research findings according to the overarching themes and subthemes identified in the study.

7.4.1 Key and enabling competencies to improve practice

The findings emphasised the importance of key and enabling competencies that reflect the personal and professional attributes required to support meaningful practice in CDDB (see section 5.2). Based on further analysis of datasets, six domains of key competencies to support CDDB were identified, namely, knowledge for practice, communication and interpersonal skills, practice-based skills, professionalism, cultural and spiritual competence, and intrapersonal skills. The competencies that resonate with the key competencies of CDDB were further informed by the components described by NICE (2015), the scoping review of Asian curricula (section 4.3.1), stakeholders' interviews (see section 5.2), faculty curriculum mapping (see section 6.2), and focus group discussion with key participants (see section 6.3).

7.4.1.1 Knowledge for practice

Findings reflected that caring for the dying patient is a challenging task, particularly for novice nurses, as confirmed by Costello (2006) and Arbour et al. (2015). The majority of participants' knowledge about CDDB was developed through the process of meaning-making and social interaction with patients, families, mentors and healthcare practitioners. Such personal knowledge was most often practised by senior clinical instructors and advanced students (see section 5.2.1). However, without adequate training in end of life assessment, personal knowledge was often resorted to rather than empirical knowledge. Empirical knowing - i.e. that based on scientific and evidence-based knowledge - is 'the heart of nursing sciences' (Smith-Stoner, 2011, p. 5). If nurses lack empirical knowledge in CDDB, they may fail to recognise patients' needs and preferences, and be unable to provide dignified care for dying patients and their families. This study further shared similar findings to those of Smith-Stoner (2011), that student nurses must have knowledge about theory and evidence-based practice in EoLC. Nursing faculties should improve the empirical knowledge imparted to students, with enabling competencies relating to understanding facts and evidence-based information about CDDB and recognising physical and non-physical signs and symptoms at the end of life. Findings also suggest that students need to learn about the impact of DDB-related issues on patients and their families, and to value patient and family preferences that may influence CDDB in general. Students should be further encouraged to learn about the basic physiology of illness, the dying and death trajectory, behavioural

sciences, culture and religion, and concepts and philosophy of palliative care and EoLC (see sections 4.3.1, 6.3.1.1 and 6.3.2.1).

7.4.1.2 Communication and interpersonal skills

Findings indicated that the students in this study lacked adequate and effective therapeutic communication skills when working with dying patients and their families. The participants' views support previous studies that have shown that health professionals should be able to provide adequate support and information during the end of life care decision-making process (Costello, 2006; Ranse et al., 2013). Findings thus shared similar conclusions with those of Johnston et al. (2006), Smith-Stoner (2011) and Bloomfield et al., (2015), that communication and interpersonal skills are the key competency of CDDB that must be promoted during undergraduate training. Smith-Stoner (2011) further suggested that skilled communication at the time of death includes easily understood descriptions of events, allowing appropriate time for patients and families to ask questions, and time for the nurse to listen and respond to queries and needs. Nurse educators and key participants particularly suggested that students should learn about principles and techniques of effective communication and breaking bad news. This finding is in line with Deweys' postulation about the urgency of habits and communication in daily practice. Patient- and family-centred care as the foundation in building therapeutic communication and relationships with the dying patient, family, and other health practitioners (see section 2.4.1.4) is further discussed in the following section.

7.4.1.3 Professionalism

Professionalism as a key competency relates to important values which underline the provision of practice of CDDB and the precursor of professional and meaningful relationships. This key competency, supported by enabling competencies, focuses on understanding ethics and values, critical thinking and decision-making, roles and responsibilities, and interdisciplinary teamwork. The importance of holistic and humanistic principles are further supported, along with person-centred care to maintain dignity among patients (Smith-Stoner, 2011; NICE, 2015; NHS England, 2015). The findings of this study add to this family-centred care, which is as important as person-centred care in maintaining professionalism in CDDB (see sections 2.4.1.4 and 5.2.3).

Ethical and legal issues relating to death and dying were raised during interviews, including the ethical and moral dilemmas often faced by students and nurses when they become deeply engaged in caregiving relationships (see section 5.2.1). Nurses are expected to become both caregivers and advocates of dying patients and their families (Arbour et al., 2013), and in doing so they must demonstrate extensive knowledge about ethical-legal issues, as well as the ability to think critically and make appropriate clinical decisions. Students need to understand such complex issues as deciding between life-sustaining treatment and termination of treatment, and organ and tissue donation,

particularly for patients with sustained trauma (Smith-Stoner, 2011). Such topics were identified in the Asian scoping review (see section 4.3.1). However, none of the participants in this study reported having discussed organ and tissue donation as a part of CDDB practice. Advance Care Planning (ACP) had also rarely been discussed by participants in this study, suggesting that this needs to be included in the current curriculum so that students and graduate nurses can become advocates for patients' dignity (see section 6.4.1.4). Takenouchi (2018) suggests that educational content relating to ACP should be introduced as a module in standard nursing education, so that nurses can become advocates for patient's dignity.

7.4.1.4 Intrapersonal skills

Findings confirmed the importance of intrapersonal skills as the key competency of CDDB, encompassing personal resources, self-awareness, and self-care (EAPC, 2010; NICE, 2015). In this study, participants' personal resources included resilience, thinking 'outside of the box', creativity, compassion, commitment, and courage (see section 6.4.1.6). Personal knowing entails using self-awareness to reflect upon the impact of one's interactions with other individuals, and on the value of both therapeutic nurse-patient relationships (Mok et al., 2004; Johnston et al., 2006; Smith-Stoner, 2011) and student-teacher relationships (Poultney et al., 2014; Kim, 2017). Developing self-awareness of one's own distress and knowing how to find help to reduce emotional disturbance (e.g. via self-care) is further needed (see section 6.3.2.1). Such self-awareness forms a part of personal knowledge (Carper, 1978), which can enable individuals to select particular coping strategies to manage their negative emotions. Critical reflection and internal dialogue can contribute to developing self-awareness and personal transformative actions. This can be facilitated through applying transformative education in dying, death and bereavement (Mezirow, 2000; Mallory, 2003; Smith-Stoner, 2011). Recognising and selecting appropriate coping strategies can further help students to reduce emotional burdens and to protect them from the cumulative stress that can lead to uncompassionate behaviours (Edo-Gual et al., 2015). Several authors have developed learning models to support professional learning in EoLC and to improve nurses' coping skills in encountering negative impacts of dying and death exposures (McIllwane et al., 2007; Bailey et al., 2014; Edu-Gual et al., 2015). Overall, developing and strengthening intrapersonal skills should be facilitated during the undergraduate training period and thus scaffolded in the curriculum.

7.4.1.5 Cultural and spiritual care

The findings of this study highlighted that the different religious and cultural perspectives of patients' family members often presented barriers to nurses' providing social and emotional support. For example, traditional folk beliefs about the taboo of death were found to impede normal ward business, as well as conversations concerning the end of life (see section 5.2.2). People and society are generally inclined towards a reluctance

to talk about, think about, or plan for death, since this is a complicated topic and evokes fearful feelings (Chan et al., 2009; Engler et al., 2010; Parry et al., 2011). Recent studies have revealed the centrality of patients' and family caregivers' values and belief systems in palliative care services in Indonesia (Rochmawati et al., 2018; Nuraini et al., 2018; Kristanti et al., 2019). These studies have confirmed that cultural diversity contributes to caring regimens regardless of age, religion, ethnicity or illness status.

In a collectivist society, the family are positioned as a necessary support for patients and as primary decision-makers (Hofstede, 2001; Gire et al., 2014). Nurses should be aware of any potential problems and be able to accommodate dying patients and their family preferences (Niedderiter, 2009; Smith-Stoner, 2011). Healthcare practitioners thus sometimes need to be pragmatic when assessing spiritual needs, choosing the appropriate tools and selecting interventions relevant to patients' preferences and the needs of their family. Critical reflection is necessary as an essential part of the learning process, both for beginner and more advanced or expert nurses (Benner, 2015). However, this can cause internal conflict, as demonstrated by novice students and nurses in this study (see sections 5.2.2 and 5.3.5), and as confirmed by Nieddrieter (2009) and Johnson (2009). Various practice guidance documents, as well as the research literature, have reinforced this need (National End of Life Care Programme 2010; NICE, 2014). However, none of these studies have reported on the cultural and religious approaches to EoLC in non-western settings, and therefore this warrants further exploration. Cultural and spiritual care education and training is therefore necessary to enhance nurses' understanding of spiritual needs.

7.4.1.6 Practice-based skills

As described in the literature, students' and nurses' recognition of the imminence of the end of life may be either spontaneous and traumatic, or as a result of prolonged disease progression. During the EoL period , the patient and family need to realise that death is imminent, and students and nurses need to provide opportunities for the family to have as much contact with the dying patient as possible (Smith-Stoner, 2011). Smith-Stoner further suggests that the focus of care at the time of death is to follow patients' wishes about death rituals and to help the family say goodbye. From the perspective of tranformative learning, this type of situation triggers nurses to move forwards and take initiatives which are necessary to create a meaningful practice. Thus, nurses must have relevant practice-based skills as the key competency to provide CDDB, supported by enabling competencies such as assessment, communication, pain management, nursing comfort care, care after death, spiritual care, and bereavement care (see sections 5.2 and 6.3.1).

In contrast to the focus on communication and empathy suggested by Smith-Stoner for the EoL period, the study findings showed that students were encouraged by their clinical instructors to maintain their 'professional' outlook, adopting a task-based focus

during after-death care. Students often dealt with the patient's death declaration, handled the deceased in the wards, and transferred the body to the mortuary unit (see section 5.2.4). Students were also often required to care for the deceased regardless of age, gender, ethnicity, religion or illness status (see section 5.2.4) as mentioned in the previous studies (Ek et al., 2014; Adesina et al., 2014; Parry et al., 2014; Nwozichi et al., 2015). It has therefore been suggested that nurses must be available to support both bereaved families and students when facing such a sensitive period (Smith-Stoner, 2011; Parry et al., 2011; Nwozichi et al., 2015).

Four fundamental aspects emerged in relation to caring for the dead body: maintaining the physical appearance, providing comfort, performing after death rites, and managing distress (see sections 5.2.1-5.2.4), which corroborated the findings of Gerow et al. (2010), Smith-Stoner (2011) and Loos et al. (2014). Whilst it has been suggested that learning to care for the dead body using practical laboratory experience and simulation-based learning is important (Smith-Stoner, 2011), the findings of this study confirmed the absence of practice guidelines, which led to uncertainty in handling the deceased and personal distress (see section 5.3.2). It is apparent, therefore, that transparent procedures for conducting care after death and mental preparation are needed, and should be taught in the pre-clinical stage.

7.4.2 Barriers and challenges in professional relationships

The results of this study highlight the importance of professional relationships as one of the key components in CDDB (see section 5.4). The findings also support those of earlier studies of staff and student relationships in EoLCE (Brien et al., 2008; Chow et al., 2014; Poultney et al., 2014; Bassah et al., 2016; Kim, 2017). Professional relationships can be facilitated through student-teacher interaction, reflection and engagement, role modelling, and through the social learning environment. These elements are the building blocks of professional agency in teaching and practice, to support the establishment of professional relationships and meaningful practice.

7.4.2.1 Student-teacher interaction

Student-teacher interaction is a form of social interaction that stimulates the process of knowledge construction and meaning-making (Dewey, 1969). Students in this study, however, indicated the potential for power imbalances to undermine their voices, and, as a consequence, teachers sometimes missed valuable information about the nature of students' clinical learning experiences (see sections 5.3.3-5.3.4). Within the teacher-centred learning model, power may tend to dominate the process of knowledge transfer from the teacher, as the 'knowledge supplier', to their students, as the 'knowledge containers'. Such hierarchical relationships between nurse educators and students may result in a 'banking' structure of education (Freire, 1991), rather than a dialogic relationship, and such power imbalances may have a negative impact on the mental and emotional well-being of nursing students. Educational institutions therefore need to

give credit to individual and collective aspects in the curriculum that enable students to convey their inner voices and to create meaningful engagement in practice and learning (Brien et al., 2008; Todaro-Franceschi et al., 2012). This is congruent with the ideas of Dewey (1978), which value students' direct experiences as the central apparatus of the learning process.

7.4.2.2 Role modelling

Professional role modelling may be viewed as a clinical learning approach which facilitates the improvement of students' self-efficacy in EoLC (Bandura, 1976; Ward, 2017), and thus facilitates their meaningful engagement in learning and practice. As role models, nurse educator participants acknowledged the importance of their professional roles and responsibilities in developing students' understandings of dying, death and EoLC practice. However, findings revealed unclear roles and responsibilities (see section 5.4.2), lack of professional training (see section 7.4.2.2) and limited resource provision and access (see section 7.4.2.3), which may place constraints on teaching in the clinical setting. It was further evident that informal coaching often occurs through a process of socialisation (see sections 5.3.3-5.5.4). Teachers need to understand students' characteristics and the stages through which they travel on their journey towards better understanding (Vygotsky, 1978; van der Wrath et al., 2015). Lack of support and facilitation during clinical learning practice can further widen the gap of professional relationships among students, nurse educators and practitioners. Such a culture serves to prevent students from gaining meaningful learning experiences (Chow et al., 2013; Poultney et al., 2013) and thus inhibits the development of their competencies and self-confidence, perhaps even threatening their professional identity as nurses in the future. Nurse educators thus need to improve their expertise and commitment to developing emancipation and becoming agents of change (Freire, 1991) in transforming and strengthening the overall quality of education.

7.4.2.3 Reflection and engagement

Meaningful relationships are central to fostering a 'personal' approach in nursing practice and learning about CDDB. In this study, nurse educators revealed several examples of personal reflection in the course of their teaching. Reflection and engagement were reported to enhance participants' professional and meaningful relationships, thereby enabling deeper engagement in clinical learning and practice opportunities relating to CDDB. However, the dissonance of personal versus professional values sometimes presented a challenge in developing caregiving relationships (see section 7.4.1.2). Establishing professional relationships in clinical learning thus requires boundaries between teachers and students, patients/families, and other healthcare practitioners. Without such clear demarcation lines, personal and professional boundaries can become easily blurred. Published policies state the importance of nurses maintaining personal and professional boundaries to support

professionalism (Nursing and Midwifery Board of Australia, 2010; RCN, 2015), and such boundaries have also been shown to act as safeguards for health practitioners' well-being (Griffith, 2013). Critical reflection is therefore essential to generate self-awareness, which in turn enables nurse educators to learn why, how and when they may need to shift their roles as teachers, colleagues and/or friends. Critical reflection is similarly necessary in evaluating teaching and learning both in the classroom and the clinical setting. Such findings confirm that critical reflection and dialogue contribute to transformation of the frame of reference, which leads to better orientation in practice (Mezirow, 2000). The deployment of a critical approach comprises a new insight in teaching and learning about dying and death in Indonesia, and is further discussed in Chapter 9.

7.4.2.4 Social learning environment

Findings reveal that some students received inadequate support from clinical mentors, which made it challenging for them when engaging with dying patients and bereaved families during the clinical learning period (see section 5.3.3). A supportive learning environment is considered a key building block of meaningful engagement in nursing practice and education (Lave and Wenger, 1991; Conell et al., 2011). Creating a caring and supportive environment is necessary to improve student-teacher relationships and to enhance students' classroom and clinical learning performance and resilience (Poultney et al., 2014; Froneman, 2016). However, the absence of palliative care and hospice units in most teaching hospitals can inhibit the experience of meaningful learning experiences (Bassah et al., 2014), which was a major concern among nurse educators and key participants in this study. They suggested using inpatient wards, with nurses already trained in palliative care and EoLC, as clinical learning units. However, inadequate knowledge transfers can occurr when students cannot practice what they have learnt during palliative care training in the classroom. Strengthening communication and collaboration between faculty staff and clinical instructors are therefore needed (Bassah et al., 2018). As attempts to provide different learning experiences, students may also visit community-based healthcare services affiliated to teaching hospitals and NGOs, and aged-care facilities within affordable distances of the campus area (see sections 6.3.3.2-6.3.3.3). Likewise, other studies confirmed that students may take part in field visits to community-based health services or to funeral services (Kwakkeboom et al., 2010; Pullis et al., 2012).

Students further need a non-threatening learning environment in order to support their own sense of emotional well-being, which is key to learning about EoL in all domains (Ward, 2017). As suggested by several participants in this study (see section 6.3.2.3), simulation-based learning can therefore be considered as an alternative method for improving practical-based skills in CDDB (Smith-Stoner, 2009; Bloomfield et al., 2015; Lippe et al., 2015; Lewis et al., 2016). Using simulated scenarios allows the student to

experience a level of challenge suitable for their novice status, within a safe environment (Traynor et al., 2010). Thus, recognition of learning environments beyond the classroom as contexts in which students live and learn potentiates a culture of integration and community, which celebrates the complexities and interactions of higher education and ongoing learning. Exploration of community learning engagement in CDDB is beyond the scope of this study, yet warrants further examination.

7.4.3 Support and facilitation in teaching and learning

Through this study, participants mentioned difficulties and challenges in the delivery of teaching and learning surrounding death and dying, in both classroom and clinical settings, and related care of the dying to unstructured and unintended or 'incidental' learning activities. Limited support and facilitation provided by institutions can further create significant barriers relating to preparation and support, personal and professional development, and resources and access, which thus challenge the clinical teaching and learning process (see sections 7.4.2-7.4.3).

7.4.3.1 Preparation and support

The findings highlighted how participants' emotions developed as a result of previous experiences with DDB could either limit or enhance their learning about EoLC and CDDB. This finding is similar to those of other studies (Allchin, 2006; Ek et al., 2013; Adesina et al., 2014; Ward, 2017). Thus, availability of social and emotional support is necessary when dealing with dying and death in the clinical learning environment. Faculty staff play a significant role in strengthening students' communication skills and helping them to prepare mentally and emotionally before entering clinical learning (Brien et al., 2008; Edo-Gual et al., 2015). However, lack of time, lack of teaching and mentoring skills, combined with limited resources and access, contributed to a lack of counselling and briefing/debriefing sessions (see sections 5.4.1 and 5.4.4). Students and nurses thus often used informal supports, and managed their distress and dissatisfactions through peer support or self-management (see section 5.3.3). A study conducted by Vis et al. (2016) found that a peer-led debriefing method reduced stress and facilitated collective and mutual support, healing and self-help among staff who experienced the deaths of residents in nursing homes. Such efforts can further minimise disenfranchised grief (Doka, 2010 cited in Vis et al., 2016). However, Poultney et al. (2014) stressed the importance of developing structured briefing and debriefing activities after exposure to dying and death in clinical learning. Likewise, Engler et al. (2010) and Cook et al. (2014) support the need for nurses to attend professional training on clinical counselling, briefing and debriefing, focusing on managing loss, grief and bereveament. In addition, the topics of emotional management and spiritual well-being clearly need to be embedded in current clinical practice standards and undergraduate nursing curricula (McIllwane et al., 2007; Bratjman et al., 2009; Bailey et al., 2014; Edo-

Gual et al., 2015), since these subjects aim to prepare mental and spiritual capacity both during the training period and after graduation.

7.4.3.2 Clinical mentoring and supervision

Clinical learning practice is vital for supporting the development of students' competence and confidence in CDDB. Findings thus indicate that additional structured mental and emotional training programmes are required to minimise distress resulting from the caregiving process and relationships (see sections 5.3.2 and 6.3.2), as confirmed in other studies (Brien et al., 2008; Bailey et al., 2014; Edo-Gual et al., 2015). Participants thus suggested creating opportunities for individual meetings (in addition to structured teaching, expert mentor/preceptor meetings, briefing and debriefing, clinical learning rules and regulations), in order to facilitate mutual trust and professional learning guidance.

Nurse educators play a significant role in creating meaningful learning experiences for students during clinical placement. Findings highlighted that students found it difficult to transfer palliative care knowledge from the classroom to clinical practice, which confirmed the study findings of Bassah et al. (2016). Such knowledge and skills is often missed in assessment by clinical mentors (see sections 5.2.4, 5.4.2 and 5.5.1). The literature reveals that the evaluation of clinical learning practice in palliative care can be challenging for nurse educators (Jeffers, 2013; Poultney et al., 2014). A recent study discovered that providing prompt feedback after students completed physical care activities can help students to evaluate their self-efficacy (Ward, 2017). Ward noticed that assessing students' performance when providing emotional support was more difficult than assessing provision of physical care, particularly without feedback from patients, family members or the nursing staff during practice. Bassah et al. (2018) affirms that a lack of supervised palliative care in clinical practice challenges the achievement of clinical competencies among pre-registration students in resource-limited settings. Such studies suggest that nurse educators need to increase their competencies in delivering structured clinical mentoring and supervision programmes. The findings of this study confirmed an absence of trained faculty staff and clinical instructors, and thus reveal the need for continuing education and in-house training in CDDB. This is further discussed in Chapter 9.

7.4.3.3 Professional development

The findings of this study demonstrate that negative experiences in dealing with dying and death, and lack of knowledge and skills in practice, pose a challenge to nurse educators in engaging with dying patients and their families (see section 7.4.1.5). Such situations may indicate a lack of readiness on the part of a faculty for the integration of EoLC content into the curriculum (Todaro-Fransceschi et al., 2012; Ferrell et al., 2015; Ward, 2017). As a result, they may experience further difficulties in delivering relevant content and tackling practical issues during clinical teaching and supervision. Nurse

educators expressed the further need to improve their knowledge and practice in areas including communication and interpersonal skills, ethical-legal issues, and cultural-spiritual care in CDDB (see section 5.2). The limited number of healthcare professionals trained in EoLC also appears to be a significant constraint in the provision of CDDB in higher nursing education. The establishment of continuing education and in-service training is therefore vital to improve knowledge and skills. Various teaching and learning strategies are available to improve self-competence in CDDB, for example, blended learning programmes (Kavanaugh et al., 2009; Pullsford et al., 2014), online learning (e-ELCA, 2015; Wochna et al., 2015), and café design principles using appreciative inquiry (Kanaskie, 2011). Takenouchi et al. (2011) suggest that improving partnerships between academics and practitioners is crucial in developing vigorous educational programs. Further discussion relating to professional development is presented in Chapter 9.

7.4.3.4 Resources and access provision

The findings highlighted various organisational and environmental constraints that may influence the teaching and learning process. These relate to time, workloads, policy and guidelines, facilities, and lack of formal training in EoLC (see sections 5.4.1 and 5.4.4). These findings also corroborate those of other studies (Johnson, 2009; Wilson et al., 211; Todaro-Franceschi et al., 2012; Jeffers, 2013). In response to such issues, Kim (2017) has further suggested 'unburdening the curriculum' by integrating the content of classroom and clinical learning. This is discussed further in section 7.4.4 and Chapter 9.

The findings of this study confirmed those of Johnson (2011) and Wilson et al. (2011), that a crowded curriculum, limited pedagogy and teaching strategies, and a lack of clinical learning experiences have constrained students' learning about CDDB. According to transformative learning, the crowded curriculum is not an inevitable or unsolvable problem, but rather a challenge that may be powerfully reframed by considering threshold concepts (McAllister, 2017, p. 46). Threshold concepts are concepts which, once understood, can change the way in which a student thinks about a subject. Following the original concept developed by Meyer and Land (2003), current educational research recognises that threshold concepts are 'akin to a portal, opening up a new and previously inaccessible way of thinking about something' (Fouberg, 2013). It is known that core concepts, as the building blocks of understanding subjects, do not necessarily changes students' perspectives about particular issues. Threshold concepts, on the other hand, are transformative, probably irreversible, integrative, bounded and troublesome (Fouberg, 2013). As suggested by McAllister (2017), nurse educators who utilise threshold concepts in the curriculum are thereby able to develop meaningful learning outcomes, as well as to introduce challenging issues, which are complex, uncertain, ambiguous, hidden and likely to stimulate debate surrounding

practice of CDDB. For example, the use of sedation at the end of life may raise a debate among different ethnicities and religious faith. Educators should therefore ensure that such concepts are accommodated and understood on the journey from novice to mastery within their discipline (Higgs, 2014, p.14). Hence, curriculum developers and nurse educators need to develop learning modules encompassing specific topics, test these, and develop planned strategies to maximise the taught content.

7.4.4 Negotiated pedagogy and teaching practice

Developing well-structured curriculum and pedagogy practice to prepare students in the pre-clinical and clinical stages is crucial. Negotiating the 'what', 'how', 'when' and 'where' of the curriculum further gives students and nurse educators ownership of their teaching and learning experiences, increases student motivation, and fosters a strong engagement in the learning process (Edward, 2011). Five key aspects of negotiated pedagogy and teaching practice emerged from this study: meaningful and measurable learning outcomes, scaffolding the curriculum, transforming frames of reference in teaching and learning, authenticity in practice amd learning, and collaboration and partnerships.

7.4.4.1 Meaningful and measureable learning outcomes

It was evident in this study that clinical practice in CDDB is intangible and that dying and death represent a 'hidden curriculum'. If students practise without clear learning objectives, clinical instructors may be unable to guide and assess them appropriately (see section 5.4.4). Through specific learning outcomes, educators may also be better able to identify relevant teaching and assessment methods (Kern et al., 2009; Harden, 2010). Identification of meaningful and measureable learning outcomes and authentic evaluation methods should therefore be considered in curriculum design (Smith-Stoner, 2011; Kim, 2017). However, predetermined learning outcomes may prevent students from experiencing an in-depth learning process in clinical practice (Anderson, 2010). Curriculum developers should therefore be tasked with developing meaningful learning outcomes using broad conceptualisations, instead of specific objectives with narrow scope (Cooper, 2007; Adams, 2011; Tam, 2011). This may be achieved through the application of the 'Backwards method' (Wiggen and Tiegh, 2010). In constrast to traditional content-based methods, a backwards design is a method that enables nurse educators to start with goals or outcomes, create or plan assessments based on these, and finally put together lesson plans (Ornstein et al., 2017). When developing measureable learning outcomes, EAPC (2010) and O'Connor et al. (2016) suggest that curriculum developers may utilise a revised Bloom's taxonomy of learning (Krathwohl, 2002).

Creating meaningful and measurable learning outcomes should also accommodate complex and uncertain issues related to EoLC, as well as consider different levels of learning (see sections 5.5.2, 6.3.3.1 and 6.3.3.4). One participant in the focus group

discussion reported that the new curriculum (post-2015) adds the intended learning outcomes, including in the nursing foundation subjects and elective subjects (see section 6.3.1). However, students perceived that having compulsory learning objectives in CDDB amounted to a harsh expection to 'see someone who is dying or dies' during clinical practice (see section 5.5.3). In responding to such constraints, curriculum developers should be mindful of and adequately trained in EoLC. Developing learning outcomes should also include dialogue with stakeholders and users and ongoing reflection (Freire, 1990). Such critical reflection generates new knowledge, which replaces irrelevant prior knowledge and assumptions as part of a transformative learning process (Mezirow, 2000). This is central to negotiating pedagogy and teaching practice as a part of overall curriculum reform. Detailed discussion of developing meaningful and measureable learning outcomes is presented in Chapter 9.

7.4.4.2 Scaffolding the curriculum

The findings of this study confirmed ithe existence of incongruent learning experiences, an absence of guidelines and policies for students, educators and practitioners on how to provide EoLC (Johnson, 2011; Todaro-Franceschi et al., 2012; Condon et al., 2014), and a presence of gaps between theory and practice in EoLC (Bassah et al., 2016; 2018). In narrowing the gap between theory and practice, the findings support the idea that the development of content and pedagogical practice should align with current trends and issues in the healthcare system (Kern et al., 2009; Lee et al., 2013). Thus, scaffolding methods, and the experiential learning model, allow an iterative learning process (Vygotsky, 1978; Kolb, 1994; Kern et al., 2009). To this purpose, enabling key competencies and meaningful learning outcomes should be built upon professional attributes and skills for practice in CDDB (see section 5.2). The findings thus suggested that CDDB education should be classified in terms of different levels of competence (see section 6.3.1).

Based on the novice-to-expert model of professional development, Benner (1984) states that novice students gradually increase their capacity from 'know about nothing' to 'know more about something'. This model coincides with the social cultural theory of 'zone of proximal learning' (Vygotsky, 1978), which was extended by Miller (2010) to baseline performance-based evaluation within a competency-based learning model. Van der Wrath et al. (2015) asserts that curriculum content should be co-created using a social constructivist model to support meaningful learning outcomes, which can contribute to inspiring students and thus transforming their lives. These activities require nurse educators to conduct critical reflection, dialogue and rational discourse (McAllister, 2017) to ensure an impactful transformation in the curriculum. The findings of the interviews and focus group confirmed the urgency of reviewing content areas in CDDB during the course development process (AACN, 2015), including involvement of

experts to review the developed curriculum and gain feedback from users (Bassah, 2017). These efforts would ensure that no critical content has been omitted.

7.4.4.3 Frames of reference in practising and learning

The findings highlighted that unstandardized knowledge and skills acquisition arose when individuals learned via socialisation or via a hidden curriculum. Consequently, different perceptions of palliative care and EoLC can occur among faculty staff members and clinical instructors, which can impact on teaching and practice (Lippe et al., 2015) and can create a 'disorienting dilemma' among students (Mezirow, 1991). This in turn can discourage students from supporting dying patients and their families, or from advocating for them or indeed for themselves. Equipping nurse educators with current knowledge and skills about EoLC and CDDB is therefore necessary and may be encouraged through methods such as facilitating access to research journal databases and creating sharing and learning forums in nursing faculties (Bassah et al., 2018).

The findings further confirmed that multiple ways of knowing should become the foundation of practice and learning about CDDB (Smith-Stoner, 2011). The inadequacy of empirical and ethical-legal knowledge were evident in this study (see sections 5.2.1 and 5.3.1), and these have led to disempowerment in clinical nursing practice and learning. Nurse educators need to become more aware of intangible aspects (beliefs, norms and values) related to dying and death and its curriculum, so that they can pose questions and highlight problems (Jenning, 2017). Areas such as empathy, honesty, compassion, commitment, respect and non-judgemental attitudes are important to reflect upon. These collective values serve as a frame of reference (Mezirow, 2000) and are a significant part of the professional identity of nurses, helping to elevate nursing to a position of respect and trust within society.

Lack of involvement of clinical instructors and students in the curriculum development process was also evident (see section 5.3.1). Enabling students and nurse educators to obtain a 'sense of ownership' with the curriculum, and involving them in the process of curriculum change, is considered 'empowering the curriculum' (Mailloux, 2011; Todaro-Franceschi et al., 2014). Such efforts can also facilitate transformation of teaching and learning activities. As suggested by Kim (2017), current nursing education needs to move from a biomedical model to a nursing model, which includes 'unitary lived experiences'. Benner et al. (2010) call for radical transformation of nursing education through modification of behaviourist approaches with contructivist models. This will support the development of key competencies, negotiated pedagogy and teaching practice, professional relationships and support and facilitation, as described in sections 5.2, 5.3, 5.4, and 5.5. Hence, faculties needed to play a greater role in advocating dying and death consciousness in practice and learning situations (see section 6.3.3). Improvement of curriculum and pedagogical approaches to teaching

about dying and death in pre-clinical and clinical learning, and a need for rigorous implementation of EoLC policies in the university, are also essential.

7.4.4.4 Authenticity in practice and learning

In supporting the connection between theory and practice, the nursing curriculum needs to facilitate meaningful learning experiences for students. The study findings confirmed that meaningful learning experiences relating to dying and death can stimulate personal and professional growth, as supported by other studies (Allchin, 2006; Parry et al., 2011; Kent et al., 2012; Adesina et al., 2013; Ek et al., 2014). The provision of meaningful learning experiences enables students to discuss and construct knowledge about real-life situations, within a relevant context. However, a lack of open discussion about dying and death between students and teachers can impact on students' competence and confidence, and thus prevent them from experiencing meaningful engagement in learning. Students thus need to be engaged in 'lived experiences' (Dewey, 1981) through developing and implementing an authentic curriculum (Kim, 2017). Active, experiential-based learning enables students to gain in-depth knowledge about dying, death and caring for dying patients and their families (Kavanaugh et al., 2009; Jeffers et al., 2014; van der Wrath et al., 2015). Experiential learning further facilitates the development and acquisition of knowledge and attitudes towards dying patients (Mallory, 2003; Kavanaugh et al., 2009; Smith-Stoner, 2011; Bassah et al., 2015; van der Wrath et al., 2015).

Several pedagogical strategies can be used to establish social interactions through collaborative learning methods, for example, preparing for group projects with other students, and establishing relationships with clinicians and faculty members by asking thoughtful questions (Smith-Stoner, 2011). The sharing of experiences, or 'storytelling', is beneficial in integrating students' understandings of the art and science of nursing, as well as their self-conceptualisation as personally caring nurses (Smith-Stoner, 2011; Jo et al., 2015). Strengthening students' aesthetic knowledge in the curriculum may contribute to enhancing their sensitivity towards the suffering of dying patients and their families and their capabilities to show appropriate responses. There is value in including 'aesthetically oriented' activities, including art, film, music and literature, in EoLCE, in order to help students explore their feelings about death and dying (Smith-Stoner, 2011; Cavaye et al., 2014; Jo et al., 2015; Levitin, 2009, cited in Smith-Stoner, 2009). Overall, personal and aesthetic knowledge facilitates students' establishing professional relationships with dying patients and their families, as well as with practitioners, instructors and peers.

Furthermore, it is important to obtain feedback from both students and nurse educators in order to ensure that intended learning outcomes are achieved and teaching and learning are sustained. Following a social transformative learning approach, nurse educators may use integrated and flexible methods to identify successful and

meaningful teaching and learning processes. Previous studies have highlighted that mixed-methods approaches can be useful in this regard, including self-report instruments, reflective journals and writing assignments to evaluate students' feelings of competence and self-confidence (Lippe et al., 2015; Ward, 2017). Thus, empirical and metacognition skills (Krathwohl, 2002) that encompass aesthetic, personal, and ethical-legal and emancipatory knowledge in CDDB could be assessed, for example, using PBL and/or OSCE (Mok et al., 2002; Ellman et al., 2016).

7.4.4.5 Collaboration and partnerships

The findings indicate the need for an interdisciplinary approach to delivering teaching and learning about DDB. An inter-professional education (IPE) model is recommended by WHO (2010) and IWG (1992) in teaching complex subjects such as EoLC (Gamondi et al., 2013b; Ellman et al., 2016; Ferrell et al., 2015). This may involve palliative care nurse educators, hospital team members (palliative care physicians, nurses, ethics committees, chaplaincy members, social workers and psychologists), as well as community health practitioners, philosophers and religious clerics (Wass, 2004; Attig, 2014; ELNEC, 2015; NHS, 2015).

An interactive and collaborative environment in which this level of learning takes place is consistent with Vygotsky's (1978) view that all higher-order cognitive function can be learned and communicated socially. Thus, the development of staff who will deliver CDDB should consist of interdisciplinary teams, who represent the key to successful implementation of the EoLC curriculum (Wass, 2004; Corr, 2014; Ellman et al., 2016; Gannon et al., 2017). In such an arrangement, the entire teaching faculty and all interdisciplinary team members need to understand about the core competencies relating to IPE and EoLC, the experiential learning approach, and clinical supervision.

This study further supports the statement from EAPC (Gamondi et al., 2013b), IOM (2014) and NICE (2015) that nurses and other health professionals need to be aware of the importance of collaborative research and practice as essential pillars of the provision of high-quality EoLC and CDDB. The findings also suggest introducing death, dying and bereavement as topics for undergraduate nursing students' research projects (see section 6.3.3.3). As suggested by IOM (2014), research not only enables promotion and validation of the effectiveness of the delivery of EoLC, but also fulfils individuals' various needs.

7.5 Summary

The findings indicate important aspects that may be considered as barriers and faciliators to current curriculum implementation and pedagogical practice in CDDB. Most participants had experienced difficulties in effective communication and in establishing professional relationships during clinical practice. Unclear competencies, and a lack of

alignment between theory and practice, further make CDDB an intangible issue in both practice and learning. The findings further revealed that a lack of support and facilitation have prevented students and nurse educators from having meaningful learning experiences, both in classroom and clinical settings. The overall findings confirmed previous studies regarding the lack of guidelines on EoLCE within resource-limited settings. Analysis of the findings suggests an urgent need for reconceptualisation of the current curriculum through negotiation, integration and collaboration. The above issues underline the development of a curriculum framework, and how this may be operationalised within the current undergraduate nursing programme.

In the following section, the results of all phases of the study are presented, and a curriculum framework is explored for preparing undergraduate nursing students to care for people at the end of life. This conceptual framework encompasses the critical elements that have emerged from this study.

7.6 The proposed curriculum elements of care of the dying, dead and bereaved

This section addresses research question four: 'How is curriculum content best structured and delivered within undergraduate nursing curricula to support the provision of CDDB in Indonesia?' This study was undertaken to develop a framework to assist curriculum developers in constructing a holistic pedagogy and teaching practice to promote CDDB, since current nursing education does not accommodate such a framework. The definition of a 'curriculum framework' incorporates what a framework *is* (that is, 'a system of rules or ideas') with its *purpose* (that is, 'to plan or decide something') (Cambridge, 2008). In this study, critical elements contributing to CDDB education were identified by participants in the interviews and focus group, contributing to a shared agreement regarding needs for curriculum improvement. The generated curriculum framework provides a structure via which rules and guidelines for curriculum planning and implementation may be developed.

7.6.1 ENSURE: the building block of the structured education in CDDB for undergraduate nursing programmes

The combined findings from research stages one to three were used to identify core elements to construct a proposed framework of pedagogy and teaching practice surrounding CDDB. Based on the discussion of findings following multiple theoretical intrepretations, as presented in sections 7.3 and 7.4, four core elements were identified that should be embedded in developing EoLCE for undergraduate nursing students: **E**nabling key competencies (E), **N**egotiated content and pedagogy practice (N), **SU**pport and facilitation (SU), and professional **RE**lationships (RE). The resulting final conceptual framework is presented graphically using the acronym 'ENSURE' (see figure 7).

The ENSURE framework captures the main issues that need to be addressed in order to establish clarity and explicitly represent how CDDB may be approached in nursing education. Within this framework, future nursing education is expected to consist of a holistic curriculum and pedagogy practice that can be used to prepare nursing students for providing CDDB during their undergraduate training and after graduation.

The ENSURE framework evokes the eponymous verb ‘ensure’, meaning 'to make something certain to happen’ (Cambridge Essential English Dictionary, 2011). The framework depicts what should ideally take place at the level of learners, teachers, environment, curriculum and pedagogy. The elements of ENSURE represent a holistic curriculum, encompassing the social and cultural contexts and supports that can influence how individuals acquire knowledge, attitudes, skills and values, and in which patient- and family-centred care (PFCC) are placed at the centre of the CDDB curriculum. The following sub-sections describe the individual elements of the ENSURE framework, as identified in the study findings.

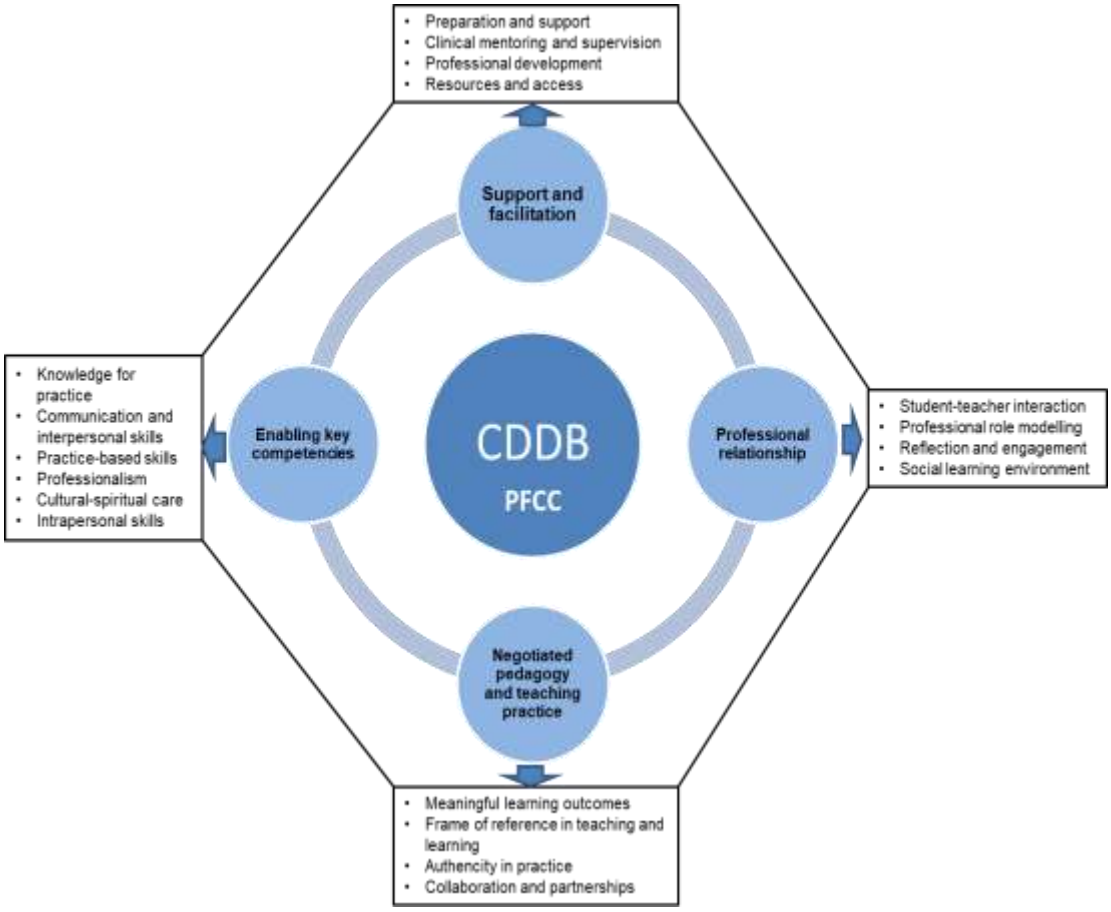

Figure 7 The ENSURE framework of education in care of the dying, dead and bereaved

7.6.1.1 Enabling key competencies and meaningful outcomes

In shaping an authentic curriculum, it is essential to develop key and enabling competencies, based on professional attributes and skills for practice, and to interpret these for generating meaningful learning outcomes and further learning objectives. Findings suggest scaffolding these competencies in the intended curriculum to enable key competency within classroom and clinical learning (see sections 5.5.2 and 6.3.1). For example, Smith-Stoner (2011) presented a constructive argument for using 'patterns of knowing' (Carper, 1978) in the context of EoLCE, known as the 'Silver Hour' model. All patterns of knowing are regarded as having two dimensions: 'knowing' (epistemological) and 'being/doing' (ontological) (McGovern, 2013). The 'knowing' dimension addresses how we come to know or understand things, and what is required to admit something as knowledge. This may be conceptualised as 'knowing that', whereas the being/doing dimension represents 'knowing how' (i.e. how nurses' knowledge is manifested in who they are and what they do) (Kennedy, 1998). Examples of these two dimensions of ways of knowing that emerged from the study findings are presented in Table 24 below. Hence, administrators and nurse educators should seek ways to enable these key competencies without 'burdening' the existing curriculum. Negotiating curriculum content and pedagogy practice can thus pave the way in achieving the targeted teaching and learning programme, as discussed in the next section.

Curriculum developers and nurse educators further need to develop meaningful and measureable learning outcomes which describe students' achievements in terms of knowledge, skills and values towards the completion of the course or training programme. Clear articulation of learning outcomes serves as the foundation for evaluating the effectiveness of the teaching and learning process (Lippe et al., 2015). Measurable learning outcomes contain three essential components: student learning behaviours, appropriate assessment methods, and specific student performance criteria/criteria for success (Harden, 2002; Kern et al., 2009). Basic essential rules apply when developing measurable learning outcomes, such as focusing on student behaviour using simple, specific action verbs, selecting appropriate assessment methods, and stating desired performance criteria (Kern et al., 2009). Many authors suggest Bloom's taxonomy of learning can be used to develop measurable learning outcomes focused on cognitive (knowledge), affective (attitudes) and psychomotor (skills) (EAPC, 2010; Ferrell et al., 2016; Brown, 2016; Bassah, 2017).

Table 24 Examples of 'knowing that' and 'knowing how' in care of the dying, dead and bereaved

Knowing that
• Dying patients may experience pain and other physical discomforts when death is approaching • The dying patient may experience a delirium when death is approaching • Dying patients and their family have specific needs and preferences • Dying patients, family and health professionals can experience fears of death and death anxiety • Individual's acceptance towards dying and death influence his/her perception, attitudes and practise behaviours • End of life patients and their family are vulnerable towards any oppressions • Grief responses might be different among cultural and beliefs • Coping with suffering and death can cause stress among patients, family, students, and health professionals • End of life patients and their family needs adequate information • The deceased body needs to be handled with dignity and respects • Transferring the dead body requires clear documentation • Care of the dying, dead and bereaved requires interdisciplinary teamwork • Dealing with dying and death needs ongoing training, preparation and evaluation
Knowing how
• To comfort a dying patient who experiences pain and other discomforts • To recognise the symptom of delirium at the end of life • To assess the needs of dying patients and their family • To recognise self and others' distress when dealing with dying and death • To provide holistic care based on needs and preferences that includes physical, psychological, cultural and spiritual dimensions • To explain about futile interventions for the family • To support the dying patients and their family to adjust to the dying phase and imminent death • To seek relevant supports to manage personal and others' distress • To provide adequate information and answer difficult questions • To care the dead body following human dignity and respect, health and safety practice, and culture and traditional rites • To coordinate with other disciplines to manage the dying patient and their family • To develop personal and professional capacity in supporting the provision of excellent care of the dying, dead and bereaved • To introduce the importance of end of life care to the professional and community in general

7.6.1.2 Negotiated pedagogy and teaching practice

This study has highlighted the debate surrounding ethical and moral issues in using specified learning outcomes (see section 5.3.1). Participants recommended that CDDB can be set as 'negotiable learning', rather than 'compulsory learning', objectives during clinical placement (see section 5.4.6). Negotiable learning objectives reflect the uncertain nature of dying and death within the clinical learning settings. On the other

hand, compulsory learning outcomes and learning objectives could be given during the pre-clinical learning stage (see section 7.5.2.1). The participants in this study were aware of the need to develop a curriculum and learning instructions using dialogue, negotiation, and collaboration between students and teachers. They further valued the notion of learner-centred approach and criticism as the foundation of constructivist philosophy. This resonates with the idea of critical pragmatic education in higher education (Forester, 2013). In creating meaningful learning outcomes, there may therefore be a need to steer away from a positivist ideology and towards humanistic and holistic principles. This is supported by the works of Smith-Stoner (2011) and McGovern et al. (2013), in proposing the use of patterns of knowing as the foundation of developing learning objectives and teaching and assessment methods.

The majority of participants supported the integration of learning in order to minimise an overloaded curriculum. Previous studies demonstrated successful integration of EoLC into undergraduate nursing education (Ramjan et al., 2010; Wallace et al., 2011; Pullis et al., 2012; Lippe, 2017). However, the integration of CDDB can be challenging due to the complexity of EoLC and its potential incompatibility with the current predominantly biomedical orientation in nursing practice. This situation mirrors the position of palliative care education as 'an orphan subject' without having a specific umbrella department, as described by Pereira et al. (2012), and this may constrain curriculum developers in attempting to integrate content into existing curricula (Dickinson et al., 2011; Pereira et al., 2012). Such discrepancies prompt a consideration of what the best options might be, following a critical pragmatic approach to the curriculum. Previous studies have described efforts to minimise overloaded curricula, and address lack of time and the limited numbers of trained mentors with EoLC expertise, by using online learning or blended learning models (Kavanaugh et al., 2013; Wochna et al., 2015; Ellman et al., 2016). Such pragmatic approaches resonate with sociocultural learning theory, in facilitating student-centred learning, problem-solving and social interactions to construct new knowledge.

Participants expressed the need to improve learning experiences relating to CDDB. Studies have confirmed that simulation-based learning can successfully improve self-competence in EoLC communication skills among nurse practitioners and undergraduate nursing students, as well as readiness to care for dying patients, ethical decision making, and inter-professional collaboration in EoLC (Smith-Stoner, 2009; Jo et al., 2015; Lippe et al., 2015; Bloomfield et al., 2015; Ellman et al., 2016; Lewis et al., 2016; Cunningham et al., 2017). Role-modeling of EoLC, particularly the communication techniques that enhance caregiving, can also be practiced in the simulation laboratory (Bloomfield et al., 2015). Utilisation of high-fidelity simulators to teach about care of the dying and after-death care could also be considered, although such devices may prove too costly (Ward, 2017). As an alternative method, Fink et al. (2015) used a standardised patient during simulation-based learning to teach about

cultural and spiritual competence in the laboratory. In this case, nurse educators may themselves require training in developing case scenarios and evaluation methods for simulation-based teaching (Lippe et al., 2015).

This study found that negotiating content and pedagogy practice in nursing curricula requires collaboration and partnerships within internal and external parties. There has been a proliferation of studies about interprofessional education (IPE) in EoLC, focusing on specific modules such as pain management (Ellman et al., 2016), communication (Wittenberg et al., 2010; Bloomfield et al., 2015), ethical and legal aspects (Izzumi et al., 2013), loss, grief and bereavement (Greenstreet, 2005; Dobratz et al., 2014), cultural and spiritual care (Ellman et al., 2012), and self-care practice (Sanders et al., 2011). IPE in EoLC can further improve communication and coordination between practitioners and patients/families (Gamondi et al., 2013b; Ellman et al., 2016), and reduce errors in care regimens, and thus contribute to working satisfaction among team members (WHO, 2010). In addition, the service-learning model has become a viable method in EoLCE, entailing direct engagement with dying patients and their families in hospital or hospice settings (Jeffers, 2015) or community settings (see section 6.3.3.2). None of these studies have discussed IPE and CDDB in undergraduate nursing programmes, which warrants further development. Based on the document reviews and analysis of interview and focus group data, IPE has been embedded in the intended curriculum since 2016, and thus has potential to be integrated within the CDDB topics identified in this study.

7.6.1.3 Supportive and facilitative environment

The study findings indicate that support and facilitation is necessary to address barriers and challenges in teaching and learning about CDDB, and may include preparation and support, clinical mentoring and supervision, professional development, resources, and access (see section 7.3.3). Findings further reveal that the presence of a supportive learning environment contributes towards the achievement of clinical competencies among students. Poultney et al. (2014) suggests that supportive learning environments for students are especially important when they are dealing with the complexities and uncertainties of EoLC in clinical learning. Building an optimal learning environment is therefore essential to develop students' and nurses' competencies in providing CDDB. Dewey (1981) affirms that students can gain knowledge through social interaction and direct action, which enables them to experience personal growth within a supportive community of practice (Kivinnen et al., 2003). For example, the use of briefing and debriefing techniques can enhance students' understanding and reduce their distress resulting from caregiving relationships during clinical practice (Traynor et al., 2010; Bloomfield et al., 2015). However, meaningful learning experiences are less effective when students do not feel accepted, facilitated and involved during clinical practice

(Conell et al., 2011). Therefore, empowering nurse educators and clinical agency is urgently required to support personal and professional growth among students.

Additional training in pre-clinical and clinical teaching and learning strategies relating to CDDB is necessary for faculty staff, clinical instructors and students. Educational institutions need to carefully assess nurse educators' teaching competence in providing CDDB. Findings further suggested a need for nursing faculties to improve resources and access, and thus support students in enabling key competencies towards a meaningful practice in CDDB. This may include access to relevant textbooks, journals and other written materials, particularly in the local (national) language, expert lecture sharing, and learning forums. Development of learning modules can ensure that students have structured content and learning objectives and that nurse educators are able to deliver and assess these (Ferrell et al., 2015; Ellman et a., 2016). Given the often limited knowledge resources and access at national level, active participation and collaboration with counterparts from international organisations can also be highly useful (Gamondi et al., 2013b; Bassah, 2018; Bailey et al., 2017).

7.6.1.4 Professional relationships

The study findings confirmed that professional relationships can foster meaningful learning experiences in CDDB. Such relationships can further faciliate meaningful relationships with dying patients and their families. The key aspects required to establish professional relationships in practice and learning are positive student-teacher interaction, reflection and engagement, role modelling, and social learning environment.

Positive student-teacher interaction can stimulate students' motivation to learn and their ability to cope with distress and pressure during the clinical learning period. Personal knowledge allows nurses to engage in 'therapeutic use of self', which forms the foundation of the nurse-patient relationship (Johnston et al., 2006; Smith-Stoner, 2011). Hence, students and nurse educators' academic, personal, professional and social situations contribute to their active participation in the clinical supervision and mentoring process.

Professional role models are valuable to students in guiding and inspiring them to provide good care for dying patients and their families. As role models, clinical instructors also act as safeguards when students encounter clinical learning problems (Poultney et al., 2013; Chow et al., 2014; Bassah et al., 2018). Based on the findings of this study, the key attributes of clinical instructors in relation to role modelling include: 1) awareness of dying and death, 2) knowledge and skills in CDDB, 3) flexibility and accessibility, 4) transparency in assessment, 5) constructive feedback, and 6) emotional support. These components were confirmed by Poultney et al. (2015), who suggested that mentoring relationships are influenced by factors including personal characteristics, professional skills, academic abilities, and the social situations of students and clinical instructors in relation to the goals, roles and responsibilities assumed by both parties.

These findings thus support those of Smith-Stoner (2011), who suggest that role modelling uses ways of knowing to enhance knowledge, attitudes and skills in CDDB, both in the classroom and clinical practice.

In this study, participants valued support and facilitation to promote the establishment of professional relationships and meaningful learning experiences during clinical practice. In attempting to accommodate the transformation of clinical nursing practice, Kim (2017) proposed a reconceptualised clinical practice model focusing on EoLC for pre-registration nursing students in Korea. This emphasised utilising a 'lived curriculum' and 'authentic learning' which facilitates meaningful learning experiences for students. Transformative learning values the importance of nurse educator agency to promote dialogue and critical reflection to faciliate transformative actions (Mezirow, 2000). Nurse educators thus need to develop their critical reflection skills and meaningful engagement during clinical teaching and supervision. Such efforts are necessary to improve their awareness and sensitivity to recognise problems and needs of their students when dealing with dying, death and bereavement.

7.6.2 The scope of ENSURE to support the implementation of CDDB in undergraduate nursing programmes

ENSURE is designed to provide a framework for developing the holistic curriculum and pedagogy practice to deliver CDDB in undergraduate nursing education. It also provides a framework to enable learners and professionals to establish an authentic personal and professional endeavour. ENSURE emphasises the meaning of personal and professional facets in understanding the processes of meaning-making, attitude formation, social interaction and critical reflection, all of which affect the construction of DDB in nursing academia and practice. In attempting the integration of ENSURE into daily teaching and learning, multiple theoretical lenses were used in this study to guide the process: scaffolding the curriculum, multiple ways of knowing, and novice-to-expert.

Pragmatism and sociocultural learning focus on the importance of contextualisation through integration, negotiation and collaboration in development, implementation and evaluation of the curriculum. These elements are necessary to create meaningful teaching and learning experiences, as aligned with professional attributes and skills for practice in CDDB. Furthermore, sociocultural theory supports the application of transformative learning, which is concerned with critical aspects of education relating to agency, power and hierarchy, injustices and inequalities. Such elements form the foundation of the development and transformation of current education and practice relating to CDDB in the nursing arena. These theories guide further integration of elements into the current curriculum thread.

Patterns of knowing as the nursing ontology and epistomology enrich the ENSURE framework and enable its operationalisation. The framework further embraces the interconnected and complementary elements of empirical, aesthetic, personal, ethical-

legal and emancipatory knowledge in practice and learning (Kennedy, 1998; Vinson, 2000; Smith-Stoner, 2011; McGovern et al., 2013). These multiple ways of knowing represent the basis of teaching and learning about uncertain events and complex interventions such as CDDB (Smith-Stoner, 2011). Such approaches thus correspond with Benner's proposal (2015) regarding the infusion of constructivist philosophy in behaviourist nursing education. This philosophical basis can guide the development of key competencies, meaningful learning outcomes, authenticity in practice, professional agency, and the framework of teaching and supervision related to CDDB, as further discussed in Chapter 9.

The findings reveal the need to develop professional competencies in CDDB among students and nurse educators. Novice-to-expert theory (Benner, 1984) can guide curriculum developers to integrate ENSURE elements into an authentic assessment and professional training programme. Benner's novice-to-expert theory embraces multiple ways of knowing as means of knowledge inquiry used by nurses, according to their level of skills acquisition. This theory has a flexible and practical nature, and thus may be easily applied to routine teaching and learning.

7.6.2.1 Scaffolding teaching and learning

The study findings informed the identification of key competencies relating to CDDB: knowledge, communication and interpersonal skills, professionalism, practice-based skills, cultural and spiritual competence, and intrapersonal skills in CDDB (see Figure 8). The findings further suggest developing the key and enabling competencies within different levels of competency (see sections 6.3.3.1-6.3.3.4). Thus, applying the novice-to-expert model can help curriculum developers and nurse educators to describe the level of acquisition of knowledge, attitudes and skills that should be developed during the undergraduate training period. This model guides the integration of ENSURE elements into a concrete teaching and learning process by considering different levels of skills acquisition: novice, advance beginner, competent, proficient and expert (Benner, 1984). This model can further help nurse educators to scaffold CDDB content across the intended curriculum and the students learning period (Benner et al., 2010). Further description of model application is discussed in Chapter 9.

Nursing tradition has long inherited the behaviourist approach, which focuses on cognitive development and calls for a radical transformation by infusing a constructivist approach (Benner et al., 2010; Benner, 2015). Nurse educators thus need to consider different world views relating to dying, death and bereavement. Course developers and nurse educators are expected to create meaningful learning outcomes that reflect the strengths, needs and interests of teachers and students alike (Kern et al., 2009; Benner et al., 2010). They also need to consider empirical knowledge as the foundation of technical and procedural skills in CDDB (Blum, 2008). Hence, developing broad learning outcomes can prevent teachers from presenting too narrow or too broad a range of

topics to their students and preventing the development of creativity, curiosity, integrity and humility among students. In this case, the inclusion of pattern of knowing as the foundation of pedagogy and teaching practice can help students and nurse educators to not only focus on physical tasks, but also expand their awareness towards holistic practice (Vinson, 2000; Smith-Stoner, 2011; McGovern et al., 2013).

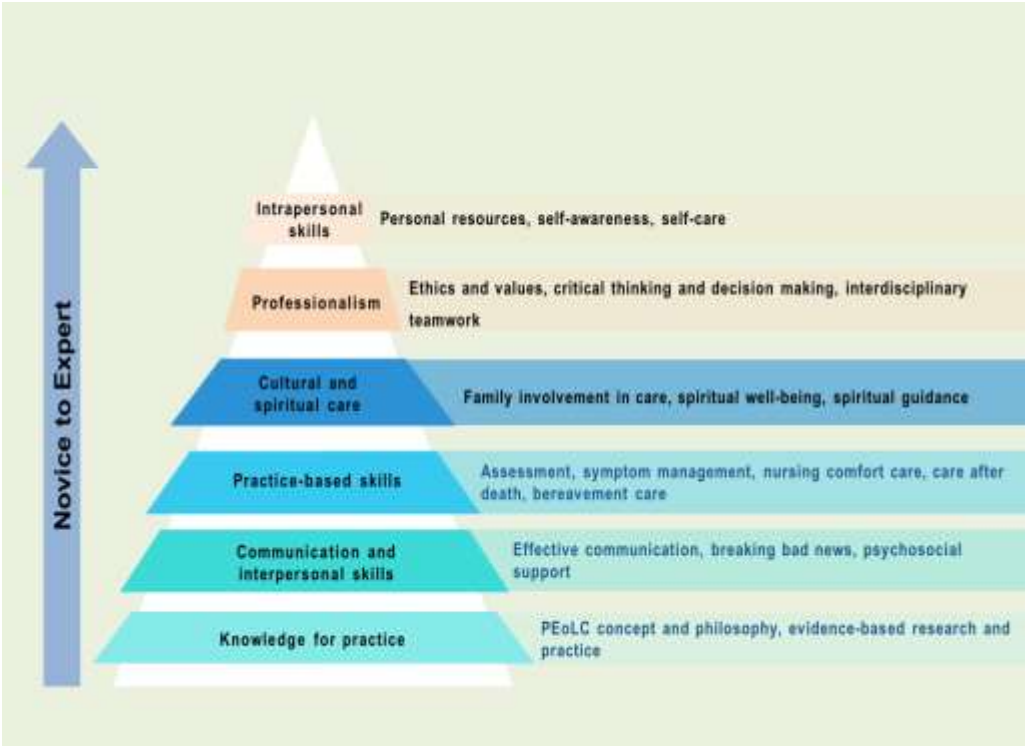

Figure 8 Key and enabling competencies in CDDB

Curriculum developers can further apply scaffolding teaching and learning, which supports dialogue and discussion between teacher and student. Scaffolding refers to learning process in which students use their own capacity and receive supervision from skillfull teachers or peers (Johnston, 2012). Nurse educators thus act as facilitators who can motivate students and stimulate their critical thinking and problem-solving. Collaborative learning is an example of scaffolding method in classroom practiced by curriculum developers of EoLCE (Smith-Stoner, 2011; Jo et al., 2015). Scaffolding also can be done in clinical placement through clinical mentoring and supervision (Walker-Reed, 2016) and near-peer teaching (McKenna et al., 2015). Such method allows novices and advance beginners to learn new clincial skills under supervision of preceptors or senior colleagues (Walker-Reed, 2016).

Based on the pre- and post-2015 local curriculum mapping exercise, there are 13 pre-clinical and eight clinical subjects relevant to CDDB competencies, as identified from the datasets (see section 6.2.1). In addition, extracurricular and pre-clinical orientation programmes may be used as potential vehicles to deliver such topics. The key competencies, as described in section 6.3.1, need to be refined, reviewed and validated through a panel consensus before being applied to the relevant courses or modules.

These activitivities further help to create a roadmap about how to build knowledge, clinical skills and professional behaviours in CDDB.

7.6.2.2 Promoting authenticity in classroom and clinical learning

As discussed in Chapter 2, few curriculum studies have discussed the integration of EoLC into nursing education (Weissman et al., 2011; Pullis et al., 2012; Pfitzinger, 2016). Several authors have recommended that nursing education should embrace a constructivist approach alongside transformative learning principles in promoting dying and death education (Mallory, 2003; Smith-Stoner, 2011; Van der Wrath et al., 2015; Kim, 2017). Such worldviews are reflected in the ENSURE framework which demand dialogue, critical reflection and rational discourse on behalf of participants in order to meaningfully engage in caregiving relationships and student-teacher mentoring relationships. This framework could also help to prevent CDDB from remaining an intangible practice and learning in health professional education. The application of ENSURE in teaching and practice requires the establishment of caregiving discourse between students and faculty staff, between faculty staff and clinical instructors, among health professionals, and with patients and their families. This facilitates self-awareness about barriers and challenges which might derive from personal, professional, organisational and/or environmental aspects. Thus, the ENSURE framework could become a formal guidance tool that allows nurse educators to hold meaningful discussions on improving engagement in practice and learning and promoting professional identity in nursing.

The constructs of a clinical competency assessment model, as proposed by Miller (1990), may be used to fill the gaps of Benner's novice-to-expert theory as a form of authentic assessment. Furthermore, Miller's pyramid model may help nurse educators to evaluate students' competency achievement throughout educational programmes. These combined theories support the scaffolding of CDDB in teaching and learning, which should be designed according to the zone of proximal development (Vygotsky, 1978). Further explanantion regarding the application of these theories is presented in section 9.4.2.

7.6.2.3 Enhancing professional agency in teaching and clinical practice

The findings of this study confirm that caring for people at the end of life requires personal and professional skills in order to manage the potential conflicts which may arise as a result of the differing social, cultural and religious backgrounds, hopes, expectations and priorities of patients, families and healthcare professionals. The findings also provide an understanding of the potential challenges which apply within local contexts, and suggest that, overall, the majority of nurses are not prepared with adequate knowledge and practice in CDDB during their undergraduate training. Nurse educators are therefore required to enhance their professional agency and to transform their frame of reference in teaching and clinical practice. The elements of ENSURE

include strengthening professional attributes and skills for practice needed for CDDB, and transforming the frame of reference for teaching and clinical practice. The notion of professional agency among nurse educators could be further achieved by considering the elements of the STAR framework (sensitivity, taking action and reflection) as a guide in delivering transformative education (McAllister., 2017). This framework encourages nurse educators to become sensitised to human issues, to link knowledge to action, and to challenge habits of mind through reflection to gain a new perspective. This will enable a transformative learning experience and facilitate the achievement of student learning outcomes (i.e. emphathetic, skilled and thoughtful). However, few faculties and clinical instructors have been trained in palliative care and end of life care. This presents a risk to the delivery of adequate knowledge and skills in CDDB (see section 5.4.1). Hence, enhancing nurse educators' professional competence in CDDB is necessary. This could be facilitated through a 'train the trainer' programme in EoLCE (Ferrell et al., 2015; Takenouchi, 2018), and/or by international visiting professors, clinical preceptor training, and expert consultations (Gamondi et al., 2013b; Bassah et al, 2014). The findings thus indicate that strengthening nurse educators' competencies and their professional roles in clinical teaching and supervision is required for novices and advance beginners (Walker-Reed, 2016). Further discussion of professional development is presented in Chapter 9.

7.6.2.4 Advancing clinical teaching and supervision

Several participants suggested that it was essential to hold teaching sessions on CDDB (see section 5.5) in order to support and facilitate professional agency in teaching and learning and to establish professional relationships. The overall findings suggested the need to generate an educational framework that can capture current needs, potential challenges, and relevant innovations. Therefore, redesigning the curriculum and negotiating the curriculum at different levels of nursing education is recommended. To this purpose, curriculum alignment theory (Biggs, 2010) suggests that educators should pay attention to the inter-relationships between learning outcomes, teaching and learning modes, and assessment methods. In the context of health professional education, attention should therefore be paid to the interrelations between curriculum orientation, proposed core competencies and learning outcomes, educational strategies, and support systems (Lee et al., 2013). Based on the global literature and the Asian scoping review of curricula, various different pedagogical strategies may be used to deliver education on CDDB, as presented in Table 25 below.

Participants in the present study reported that they valued constructivist approaches, such as problem-based learning, role play and simulation learning, as relevant strategies for teaching and learning in dying and death education. This reflects the findings of previous studies (Mok et al., 2002; Jo et al., 2015; Bloomfield et al., 2015; Lewis et al., 2016). Participants also suggested that aged care, community shelters and

primary healthcare centres could be appropriate places for learning about communication, assessment, symptom management and home care at the end of life (see section 6.3.3). Furthermore, participants appreciated that teaching and learning processes could be evaluated using both objective and subjective assessment (see section 5.5.4). Hence, the utilisation of didactic teaching and learning, combined with an experiential learning approach and outcome measurement within a pragmatic curriculum design, would appear a reasonable approach. Owing to the complexity of EoLC, an interdisciplinary approach to teaching and learning is also needed to develop a comprehensive understanding among undergraduate nursing students. The principles of social and constructivist learning can thus be applied to create and deliver IPE in dying and death education (McIllwane et al., 2007). Applying blended learning approaches, which combine face-to-face and online learning, has also been recommended as an approach to interprofessional education in dying and death (Wochna et al., 2015; Ellman et al., 2016).

Transformative education is concerned with empowerment, which is an important issue when dealing with the gaps between ideal and real practice of CDDB, as identified in findings of this study. Kim (2017) proposed goals to transform integrative knowledge into practice via clinical practice within an EoLC setting. Specific objectives included integrating clinical reasoning, understanding patient and family needs in EoLC, and having unitary perspectives in nursing. Jeffers (2014) and van der Wrath et al. (2015) recommended in-service learning, based on immersion programmes within healthcare and/or hospice organisations, in order to experience cultural and social interactions. Learning from real-life situations may thus allow students to observe, analyse and reflect on knowledge gained (Jeffers, 2014). The research findings further suggest that clinical teaching and learning can be facilitated by involving users in curriculum development and delivery, and carrying out clinical placements in several wards, particularly inpatient units, ICU and ER. for the early clinical exposure programme (year 3) and the professional programme (year 5). Such an arrangement follows Bassah et al.'s (2016, 2018) recommendation to include clinical wards with high exposure to dying and death as a suitable learning environment.

Table 25: Examples of methods used in teaching and learning in CDDB

Methods of learning	Suggested learning and teaching opportunities	Authors
Didactic learning	Seminar and workshop	Mitsunori (2013), Bailey et al. (2014), Jo et al. (2015), Cleary (2017)
Active learning	Classroom; self-directed learning; online learning; blended learning; flipped classroom	Kavanaugh et al. (2013), Tsai et al. (2015)
Collaborative learning	Case scenarios with small group discussions; art projects; group presentation	Wong et al. (2000), Jo et al. (2015), Kim (2015)
Transformative learning	Service-learning; community engagement programme	Kwakkeboom et al. (2011), Pullis et al. (2012), Jeffers et al. (2014), van der Wrath et al. (2015)
Critical reflective journal	Nursing manifesto; reflective journal; critical analysis paper	Smith-Stoner (2011), Cavaye et al. (2014)
Critical creativity	Classroom; self-directed learning; assignments	Jo et al., 2015; Cleary (2017)
Art-based learning	Drama/theatre; poetry; artworks	Smith-Stoner (2011), Cavaye et al. (2014), Jo et al. (2015)
Narratives and stories	Storytelling; expert sharing	Wong et al. (2000), Jo et al. (2015), Kim (2015)
Simulation-based learning and debrief	Laboratory simulation (High or low fidelity); simulated patient; clinical practice	Leighton et al. (2011), Mooreland et al. (2012), Bloomfield et al. (2015), Lewis et al. (2016), Lippe et al. (2017)
Online learning/ Distance learning	Reading, online discussion, assignment, flipped classroom, global classroom	Ellman et al., 2013; Conner et al. (2015), Tsai et al., 2015, Bailey et al. (2018)
Professional socialisation	Inter-professional education; seminar and workshop; simulation-based learning	Smith-Stoner, 2011; Todaro-Franceschi et al. (2012), Ellman et al. (2013)
Problem-based learning	Classroom; small group discussion; clinical practice; self-directed learning; online learning	Wong et al. (2000), Jo et al. (2015), Ellman et al. (2013)
Clinical practicum	Simulation, clinical practice experience	Chow et al. (2014), Gallagher et al. (2015), Bassah et al. (2016), Kim (2017)

7.6.2.5 Developing assessment components

The findings of this study reveal that evaluating competencies in CDDB is important, including knowledge, attitudes and skills. These are the building blocks of key and enabling competencies based on professional attributes and skills for practice in CDDB (see section 5.2). These could enable students and nurse educators to deliver appropriate care provision. However, using individual habits of mind and points of view as baselines of learning assessments can result in an over-emphasis on subjective evaluations. Thus, paying attention towards a balance of cognitive, affective and psychomotor aspects is essential when developing teaching and learning assessment (EAPC, 2010; AACN, 2016). Written objectives and outcomes are also needed to accommodate engagement between student and teacher (Krathwohl, 2001). Literature suggests that a revised Bloom's taxonomy of learning (Krathwohl, 2002) can be used in

formulating learning objectives (Cavaye et al., 2014). This subdivides learning achievements and uses behavioural terms to identify learning in the cognitive, psychomotor and affective domains. Use of a revised Bloom's taxonomy has been recommended by EAPC (2010) and AACN (2016), alongside development of course objectives using language consistent with the Baccalaureate Nursing Essentials (Mailloux, 2011; O'Connor et al., 2016). The development of learning objectives based on Bloom's taxonomy needs to be consistent with students' educational level in the programme.

As discussed in Chapter 2, several curriculum developers have introduced EoLC into the nursing curriculum by integrating learning (Ramjan et al., 2010; Wallace et al., 2011; Murray, 2015). Those curricula used a spiral approach and competency based assessment, as confirmed in more recent EoLC curriculum studies (AACN, 2016; Ellman et al., 2016; Pfizinger, 2016). Miller's pyramid model of competency asssment employs four stages: knows, know how, shows, and does, and thus is complementary to Bloom's taxonomy (knowledge, attitudes, skills). Each stage of pyramid represents different learning achievement and its assessment method. For example, knows and knows how focuses on knowledge acquisitions of CDDB that could be assessed using written, oral, or computer-based exams. Practical skills or psychomotor aspects could be further assessed using simulation and OSCEs in the laboratory settings. As the culmination of learning, students can perform practical skills and further assessed using direct observation of performance (DOPs) in the clinical or community settings. Millers' model thus corresponds with nurses' skills acquisition level (novice, advance beginner, competent, proficient and expert), as can be seen in Figure 8 below. Such combined models represent multiple strategies to enhance authentic and transparent evaluation (see sections 6.3.3.3-6.3.3.4). Further discussion surrounding assessment models is presented in Chapter 9.

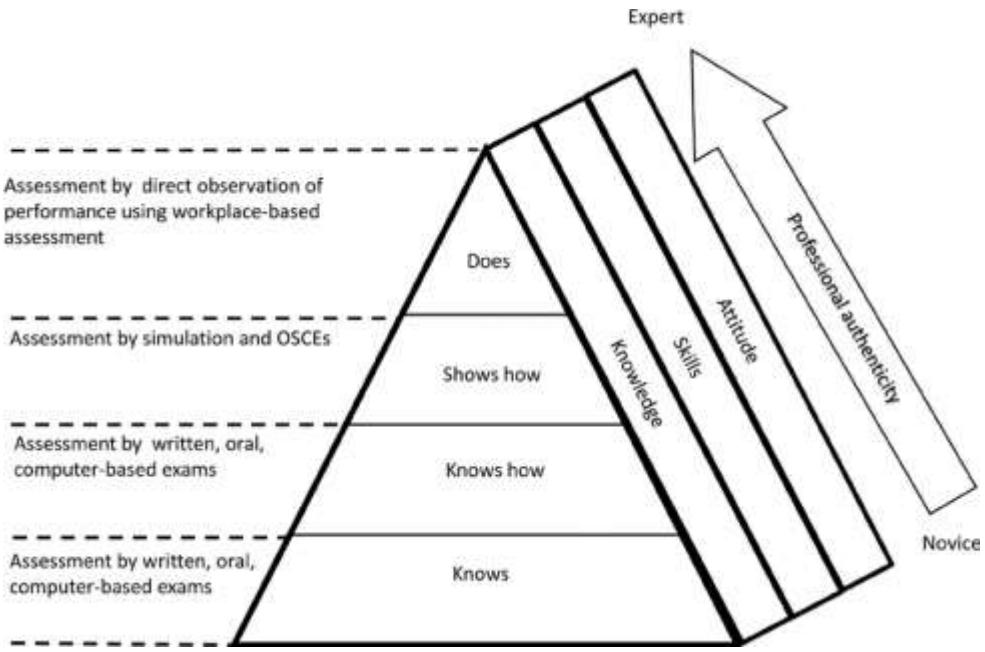

Figure 8 Miller's competency assessment model

In summary, the ENSURE elements are intended to serve as a practical resource to develop both underlying theory and developmental practice for students and nurse educators. ENSURE could be useful for teaching and learning, enabling students to improve their professional capacity and expertise in CDDB, and developing self-efficacy and self-regulation when facing dying, death and bereavement in undergraduate training. For nurse educators, this framework could serve as a source of direction for facilitating meaningful discussions and guidance regarding CDDB provision during classroom instruction and clinical learning programmes.

7.7 Conclusion

Drawing on multiple theories and following sociocultural and transformative based learning principles, I have proposed an integral curriculum thread for undergraduate nursing programmes. I identified four constructs of the curriculum framework of CDDB: enabling key competency, negotiated pedagogy and teaching practice, support and faciltation, and professional relationships. These constructs were derived empirically, and use practical pedagogical approaches and educational strategies that are supported theoretically and which follow social, cultural and transformative-based learning principles. I believe that this design template may be used for guiding curriculum developers and offers a way of thinking about preparing for teaching and learning about CDDB. Moreover, I hope that these findings can contribute to improving awareness among students and nurse educators about the importance of CDDB in education and practice settings. This chapter has provided insights that help meet all four of the research aims

8 Reflexivity

8.1 Introduction

This chapter presents the concept of reflexivity and discusses its importance in relation to descriptive qualitative multi-methods research, adopting a critical pragmatist lens. A description is given of how reflexivity has been used in this study to ensure validity, reliability and quality control, and to foster personal and professional development during an extensive period of engagement with the research.

Reflexivity relates to sensitivity to the ways in which the researcher and the research process can influence the data collected, including the role of prior assumptions and experiences (Finlay, 2002). According to Spencer et al. (2003, cited in Ali (2015)), the process of reflexivity enables researchers to demonstrate self-awareness and to acknowledge the role of values and assumptions that may influence the study findings. The terminology of reflexivity is sometimes used interchangeably with ‘reflection’ (Ali, 2015), since critical reflection forms an important aspect of reflexivity.

8.2 Reflexivity prior to the study and during data collection

Through reflecting on my own personal aims in undertaking this doctoral research, I ensured that CDDB, as conceptualised in this study, remained connected to my own personal beliefs and professional objectives. The process of reflexivity was embedded throughout the entire duration of the research.

As an 'insider' in the study setting (Lincoln and Guba, 1985), I was familiar with the systems and organisational practices of the teaching faculty. More specifically, I had been a member of the team who initiated the development of palliative care education in the university. Consequently, I had my own motives in ensuring that the study was conducted appropriately to support the future development of the nursing course. Thus, I occupied dual roles as a researcher and as a colleague and lecturer, and this potentially affected the ways in which the research interviews with participants were conducted.

While conducting the interviews, I was careful to adopt an appropriate conversational style and to establish a non-threatening environment for participants (Watts, 2014). Thus, face-to-face interviews were mostly conducted within the academic and hospital environment, and only a small number were conducted in commercial areas such as cafeterias. Although I knew some of the participants personally, and was able to leverage this pre-existing rapport to improve the quality of data elicited from participants, I was mindful of the need to maintain an ‘invisible boundary' in order to minimise personal biases and avoid compromising my professionalism.

I was also careful to incorporate a wide range of perspectives in this study, so that the presentation of one viewpoint was not considered as a single source of truth about any issue. This study was designed to elicit contributions from a broad range of stakeholders, including students, teaching staff, clinical instructors, experts, and relevant practitioners. I adopted a range of interview strategies to explore participants' worldviews, whilst being mindful of prior professional relationships and participants' situations and preferences. During the process of data coding and identification of themes, I referred extensively to the primary data provided by participants (i.e., data from individual interviews and focus group discussions). I was careful not to value one source of data over another. Indeed, constant comparisons were made between the accounts of different participants, and the data obtained from different written sources, in order to identify similarities and differences.

My supervisory research team and I appreciated the possibility that the topic of the research might result in feelings of anxiety and distress on the part of participants, and that this might affect the exchange of viewpoints and the process of data collection. Clear written information relating to potential adverse events was therefore provided in the participant information sheets. During the interviews, I found that some participants did indeed show distress. I therefore took time to ensure that such participants were able to manage their distress and were free to decide whether or not to continue with the interviews. Only one participant decided to end the interview because she was unable to manage her distress. In this case, an offer was made to refer her to the local counselling team for further help. Attending regular meetings with the research steering group also assisted me in minimising participants' distress and helped me to identify strategies to address similar issues in subsequent interviews. Likewise, there were times at which I myself identified so closely with participants' grief and sorrow that it was difficult for me to maintain a neutral position. Exploration of people's beliefs, thoughts and ideas about care of the dying, dead and bereaved have indeed challenged me to determine how best to manage my own thoughts on such topics from both a personal and professional perspective.

Overall, by engaging in constant self-reflection and adopting a mindful approach, I was able to adopt the role of a 'detached researcher' (Gough, 1999, cited in Finlay, 2002, p. 221). This enabled me to maintain clarity at each stage of the study and to possess the confidence to carry the research through to its conclusion.

8.3 Reflexivity during data analysis and interpretation

The data in this study were analysed using thematic analysis (Miles and Huberman, 1994), as described in Chapter 3. Themes were developed following an inductive approach, guided by steps one and two of Kern's model. Development and ongoing review of the emerging themes required a process of critical engagement through an

iterative process. In carrying out this activity, I was able to conduct a critical analysis of the datasets and explore the reliability and the internal and external validity of the data. This process was assisted by completing research logs, audit trails and reflective diaries, which are considered essential tools and measures to avoid potential bias in qualitative research studies.

From the initial coding through to the final thematic analysis, I incorporated critical feedback from my supervisory team and was thus able to reduce potential biases and maintain the credibility and quality of the data (Miles et al., 2013). After having separately analysed the data from each sub-study (see Chapters 3-6), data were then compared and integrated in Chapter 7. This analytical process entailed reflexivity and critical examination, and helped to establish the credibility of the findings

As described in Chapter 3, an exploratory qualitative multi-methods study design was used, following Lincoln and Guba (1985). The study's rigour was established by linking the research findings to the existing literature (see Chapter 2). This enabled me to highlight emerging knowledge as well as any remaining gaps in understanding. I was thus able to develop the ENSURE framework through a process of critical analysis and knowledge synthesis (see section 7.5.1).

Throughout the journey of my doctoral studies, I have faced numerous challenges. The process did not always run smoothly and was a very different experience from my previous academic and professional endeavours. During the first year, I experienced changes in my supervisory team, challenges in conducting the data collection and analysis, as well as various personal and professional issues. Reflecting upon those challenges and circumstances has undoubtedly led to my personal and professional growth throughout this process.

As an international student, I have struggled with expressing my ideas and conveying the research findings in the English language. This has represented a significant barrier during the writing process. Nonetheless, with ongoing support and constructive feedback from my supervisory team, and attendance at several writing-skills training courses, I have been able to develop my ability to articulate my thoughts and ideas in my scholarly writing.

In searching for the optimal approach to answer the research questions, I have experienced numerous doubts and uncertainties. I found that the use of Dewey's pragmatism opened my eyes and challenged my usual ways of thinking. However, this methodological approach also presented challenges to me as a novice researcher, since the pathways to be followed often appeared unclear. In addressing this situation, I engaged in extensive reading and critical thinking and reflection, and came to the view

that a pragmatist approach can enrich the process of inquiry and actions that lead to personal and professional growth.

This study adopted multiple theoretical lenses, comprising sociocultural and transformative based learning principles in order to uncover the critical issues and engage in higher-order conceptualisation to generate the framework of the curriculum. This also enabled further elucidation of the socio-cultural contexts relating to the study findings. The use of multiple, rather than a single, approach was chosen in order to explore problems and needs, and to analyse these from multiple perspectives before developing the curriculum.

8.4 Conclusion

This chapter has identified the ways in which the validity and reliability of the research were established throughout the study via the process of reflexivity.

The resulting ENSURE framework may be used to guide teaching and learning, as well as to build understanding among nursing students, educators and healthcare professionals. Overall, developing this framework has been a positive experience for me, and remains highly relevant to my personal and professional objectives. I hope that ENSURE will confer benefits to others in approaching CDDB and addressing its status as a hidden practice. I also hope in future to have the opportunity to continue this exploration through post-doctoral study.

The following, final chapter presents the conclusions relating to the research aims, and discusses the limitations of this study and recommendations for future nursing education and research.

9 General Conclusions and Recommendations

9.1 Introduction

This final chapter summarises the lessons learned from this research, identifying its contribution to new knowledge, its strengths and limitations, and considering the implications for policy makers and curriculum developers, nursing educational providers, and nursing practice. The chapter concludes with suggestions for future studies that could contribute to the development of nursing knowledge and nurse education.

9.2 Contribution of the study to the body of knowledge

Throughout this study, the dissonance of behaviourist and constructivist philosophy in current undergraduate nursing education presented a unique challenge in selecting appropriate conceptual models and theories to guide the study. The study findings reflect that utilisation of a progressive learning model, combined with sociocultural and transformative learning principles, can be a means of bridging the gap of existing curriculum. The pragmatic methodology used in this study attempted to combine these approaches to facilitate a sensitivity towards sociocultural factors, power and hegemony in nursing practice and learning. Thus, the term 'social transformative learning' used in this study refers to a combination of sociocultural theory and transformative learning principles.

Although transformative learning and sociocultural theory have been previously referred to in EoLCE research (Mallory, 2003; van der Wrath et al., 2015; Jeffers, 2015), the literature reveals that, to date, the adoption of such theories has been limited in CDDB research. Little has been written about the principles of social transformative learning and how to apply these in EoLCE research and CDDB curriculum design in undergraduate nursing education in resource-limited settings.

The findings of this study further reflect there has been little room for nurse educators' independence, creativity and flexibility in delivering teaching and learning. Such a situation can prevent the inclusion of CDDB as a fundamental aspect of educational processes and delivery in higher nursing education in Indonesia. This can be managed by applying a critical pragmatic approach, which promotes critical reflection, dialogue, and rational discourse to counter hegemonic challenges towards existing beliefs and systems (Forester, 2012). In strengthening the power and identity of nurses in CDDB, the application of patterns of knowing as an ontological and epistemological approach in nursing practice (Carper, 1978; Chin and Kramer, 1994), and novice-to-expert theory (Benner, 1984), can further support the social and emancipatory nature of sociocultural

theory (Vygotsky, 1958; van der Wrath et al., 2015) and transformative learning principles (Freire, 1991; Mezirow, 2000).

This study aligned the elements of critical theory and pragmatism in the higher education field (Feinberg, 2011; Forester, 2013; Brown, 2016). This research paradigm, supported by the modified Kern's six-step approach, embraced sociocultural and transformative learning principles, patterns of knowing, and novice-to-expert theory. Although such theories are not spesifically addressed CDDB, the nature of these theories can support the development of CDDB practice and education. The combination of multiple theories further helped in conducting an exploration of the content, context, outcomes, pedagogy, agency and empowerment in teaching and learning in CDDB.

9.3 Strengths and limitations of the study

9.3.1 Strengths

The qualitative multimethods design adopted in this study was a novel approach that explored the construction of the curriculum framework of EoLCE by considering multifaceted issues relating to both internal and external factors in the nursing faculty. This study is the first known curriculum development study on EoLCE to be based in a developing country and to use multiple perspectives during the development process. The combination of specific document reviews (literature reviews, scoping reviews of curricula and institutional curriculum mapping), interviews with pre-registration students and nurse educators, and a focus group with key informants (from higher education, healthcare, professional organisations and alumni/graduates), represents a novel means of identifying the complex and multiple realities of the various stakeholders.

Whilst the use of Kern's model in this study may prompt a debate concerning the use of a behaviourist element with a predominantly technical-rational approach and a lack of philosophy of practice and learning, use of this model may nonetheless accommodate a pragmatic approach, resulting in a robust, systematic and iterative process (Just et al., 2010; Bassah et al., 2015; van Zyl, 2019). This makes Kern's model appropriate for use in educational settings within busy environments and in the context of an overloaded national curriculum. Kern’s six-step approach also supports critical reflection, dialogue, creativity, practicality, negotiation, collaboration and evaluation during the curriculum development process, all of which embody Dewey’s pragmatism, Vygotsky’s sociocultural theory and Mezirow’s transformative learning.

To date, EoLC and CDDB have not been given due attention in undergraduate nursing education research in Indonesia. Few published studies have been identified to explore this issue, and existing research has predominantly been conducted in clinical settings. This study represents an initial exploration of perceptions, experiences and needs of

undergraduate students and educators in relation to structured education and training in CDDB. The findings may be used to inform future curriculum design and instructional learning in this area.

The overall study achieved its aim of developing a conceptual framework of the curriculum for CDDB and EoLCE in undergraduate nursing education in the nursing faculty of a state university. The findings suggest the need for the development of a national consensus regarding the core competencies and learning outcomes focused on CDDB in the context of Indonesia.

9.3.2 Limitations

The findings of this study must be contextualised within its limitations. This was as a small study, with limited numbers of participants and based in a single research setting. However, this may also be construed as a strength, since using a single setting permitted in-depth consideration of the participants' input. Representativeness is not a necessary goal within qualitative research, and the aim of this work was not to generalise but rather to show undertstanding about how and why the situation is as it is. This may be useful to others in similar situations. Nonetheless, future work to consider multiple sites is also recommended.

One of the major challenges of studying nursing curricula related to CDDB is dealing with limited understandings and practice related to EoLC, particularly in resource-limited settings. As a result, the scoping review of curricula and content analysis of undergraduate nursing curricula may become quickly out of date. The document review carried out was able to capture the nature of CDDB in nursing education and practice at a particular point in time. In addition, whilst several strategies were put in place to ensure the comperehensiveness of the study, it is possible that not all English language online curricular resources were able to be retrieved.

Throughout the course of this study, there were several changes to the study design, as well as delays in accessing and recruiting research participants. Only one focus group was conducted and included in the data analysis. Conducting a qualitative study within one's own educational institution also presented challenges to the novice researcher. Thus, a reflexive and critical approached was maintained throughout, with the aim of avoiding any potential biases which might impact the study results.

The curriculum framework proposed in this study was developed involving only participants from one state university in West Java province. In terms of generalisability, this site cannot necessarily be expected to represent Indonesian nursing education as a whole. Whilst this work is likely to have good face validity owing to the existence of the National Curriculum, caution may need to be applied when applying these findings to other universities.

Similarly, different universities have different structures, mechanisms and policies that may influence educational programmes and their delivery at faculty level. This study focused only on undergraduate nursing education and did not involve diploma or postgraduate nursing education. Further research is needed to employ more diverse populations, in particular, recruiting more male participants, people from diverse ethnic, faith and religious backgrounds, and with differing levels of education.

9.4 Implications of the study

This section presents the implications of the study findings for nursing education and practice, offering recommendations for areas that require further investigation. These implications have relevance to policy, practice, education and research in nursing.

9.4.1 Implications for Practice

The results of this multimethod study are relevant to faculty administrators and nurse educators who wish to promote students' knowledge, attitudes and skills relating to CDDB. The study has identified barriers and challenges in addressing CDDB in educational settings. These barriers may be managed through applying structured and measurable educational process.

The findings of this study suggest that the ENSURE framework could guide the reconceptualisation of current undergraduate nursing curricula. Faculty administratiors and nurse educators could promote and integrate the suggested key and enabling key competencies of CDDB into clinical and pre-clinical learning programmes. Nurse educators further need to conduct critical reflection on their own beliefs and assumptions, and cultivate self-motivation to expand their knowledge and skills relating to CDDB.

Both the literature review (Chapter 2) and empirical findings (Chapters 4, 5 and 6) highlighted a lack of agency and support and facilitation in pre-clinical and clinical learning, which act as barriers to fostering professional relationships and meaningful engagement in CDDB. Nurse educators could negotiate current pedagogy and teaching practice by transforming their frames of references, creating meaningful and measurable learning outcomes and applying authentic teaching methods.

Findings further reveal the importance of providing supportive and facilitative learning environments and establishing professional relationships to promote meaningful learning experiences and engagement among students. Such efforts should form a part of transformative education, which prepares students to become competent practitioners and future leaders in nursing and healthcare.

9.4.2 Implications for Education

The results of this study suggest three major implications for educational settings. These focus on integration of CDDB into the intended curriculum, designing instructional learning and teaching delivery, and curriculum implementation, evaluation and sustainability.

9.4.2.1 Integration of CDDB in the intended curriculum

The literature in EoLCE has revealed that the nursing curriculum is already overburdened, even before considering the feasibility of including further new content related to EoLC. The findings of this study highlighted that integration of CDDB content within nursing foundation courses could be a further solution for enabling student key competencies throughout the undergraduate training period. When working towards integrating CDDB into the nursing curriculum, it must be ensured that CDDB is integrated into all of this curriculum. An integration process thus takes place with concurrent modules being taught simultaneously alongside classroom and clinical teaching. The spiral curriculum approach may therefore be considered as an approach to guide the integration of ENSURE elements within the intended curriculum. A spiral curriculum approach has previously been successfully used to deliver palliative care and end of life care education in undergraduate nursing programmes (Ramjan et al., 2010; Wallace et al., 2011; Lippe, 2016) and in medical education (Ellman et al., 2015).

The findings of studies 2 and 3 specifically highlight the need to develop levels of competency among students until they are able to demonstrate the skills and behaviours necessary for providing CDDB. The findings further suggest that novice-to-expert theory (Benner, 1984) could be used to guide professional development in CDDB, according to different levels of skills acquisition in the pre-clinical and clinical learning phases. The AACN supports the integration of course content on palliative and end of life care into pre-clinical and clinical courses, including fundamentals of nursing, medical-surgical care of the adult, paediatric care, behavioural health, health assessment, pharmacology, community health, nursing research and leadership (O'Connor et al., 2016). In line with CARES (AACN, 2015 cited in O'Connor et al., 2016), the findings from this study identified a number of pre-clinical courses (n=13) and clinical learning blocks (n=8) in which CDDB content could be inserted into the intended curriculum and thus taught across different courses and periods of study (see sections 6.3.1 and 6.3.4).

9.4.2.2 Designing instructional learning and teaching delivery

Developing learning outcomes is essential in curriculum design, since it determines what students should learn and achieve in each year of study (Kern et al., 2009; Topping, 2012). However, there has been a lack of explanation regarding the basis on which such outcomes were developed. Nonetheless, the proposed learning outcomes

can be delivered using Bloom's revised taxonomy (Bloom, 1956; EAPC, 2010; O'Connor et al., 2016) for enabling key competencies of CDDB in pre-clinical and clinical learning. The findings of this study suggest that the development of curriculum and instructional design could then culminate with scaffolding CDDB learning activities within lectures, group tutorials, simulation-based learning, self-directed learning, clinical placement and service-learning in the community, while reflecting social transformative learning principles. Such suggestions support the use of multiple ways of knowing in nursing, and the novice-to-expert model as the practical framework for nurse educators to deliver pedagogy and teaching practice in CDDB. In addition, an exemplar is offered of a spiral approach in the intended curriculum, which includes the following elements: key competencies, enabling competencies and learning outcomes, potential subjects for inclusion in the intended curriculum, proposed pedagogy and assessment methods, and time allocation/phase of study, as outlined in Table 26 below.

Table 26: Exemplar of spiral approach in the intended curriculum of post-2015

Key competency (KC)	Enabling competencies (EC) / Learning outcomes (LO)	Potential subject	Pedagogy strategies	Assessment methods	Phase of study
KC 1: Knowledge for practice					
Knowledge (K)	Understand facts and evidence-based information about DDB, physical and non-physical indicators related to assessment of DDB	FoN I PEoLC	Lecture Seminar	Written test	Year 1
Attitudes (A)	Appreciate the impact of DDB-related issues; value patient and family preferences that may influence CDDB in general	FoN I Psychosocial and cultural issues in nursing PEoLC	Film Sharing forum	Reflective paper	Year 1 Year 2 Year 3
Skills (S)	Differentiate situations relating to DDB, analyse problem anticipation, assessment and management strategies	PEoLC Palliative care internship	Problem-based learning (PBL) Clinical practice	Group presentation Case analysis (SOCA)	Year 3 Year 5
KC 2: Communication and relationships					
K	Understand the effects of DDB on the person, identify and arrange goals for assessment, management options and strategies	PEoLC CCSA 1 and 2 Palliative care internship	Lecture Seminar Clinical practice	Written test Case presentation	Year 3 Year 4 Year 5
A	Demonstrate interpersonal skills, value the needs and importance of giving nursing comfort care, professional relationships with dying patients and their families	Psychosocial and cultural issues in nursing PEoLC	PBL Small group discussion (SGD) Role play	OSCE	Year 2 Year 3
S	Conduct end of life assessment, manage DDB based on holistic, safe and ethical-legal value-based care	PEoLC Palliative care internship	Simulation-based learning Clinical practice	OSCE	Year 3
KC 3: Practice-based skills					
K	Understand the effects of DDB on the person, identify and arrange goals	PEoLC Palliative care internship	Lecture Seminar Workshop	Written test Case presentation	Year 3 Year 5

	for assessment, management options and strategies				
A	Demonstrate interpersonal skills, value the needs and importance of giving nursing comfort care, professional relationships with dying patients and their families	Psychosocial and cultural issues in nursing PEoLC	PBL Small group discussion (SGD) Role play	OSCE	Year 2 Year 3
S	Conduct end of life assessment, manage DDB based on holistic, safe, and ethical-legal value-based care	PEoLC Palliative care internship	Simulation-based learning	OSCE	Year 3 Year 5
KC 4: Professionalism					
EC 4.1: Ethics and values					
K	Understand ethical principles, ethical issues related to palliative care and EoLC, decision-making, and understanding inappropriate attitudes and behaviours towards dying and death, regardless of ethnicities and religions	FON II PEoLC Palliative care internship	Lecture Seminar Workshop	Written test	Year 1 Year 3 Year 5
A	Appreciate the impact of the stigma of dying and death, the importance of ethical principles, value professionalism, acknowledge unethical and unprofessional behaviour	FON I PEoLC Palliative care internship	PBL Role play Clinical practice	Reflective essay	Year 1 Year 3 Year 5
S	Implementation of ethical principles, managing ethical dilemmas, clinical decision-making, assessment and care management	FON II PEoLC Palliative care internship	PBL Simulation-based learning	OSCE	Year 1 Year 3 Year 5
EC 4.2: Critical thinking and decision-making					
K	Identify policies, laws, guidelines, sources of policies related to CDDB	PEoLC	Lecture Seminar	Written test	Year 3
A	Critically analyse policies, appreciate the benefits of policies and how they can become barriers to CDDB	PEoLC	Lecture Seminar	Critical review	Year 3
S	Implementation and analysis of health policies and regulations	PEoLC	Lecture Seminar	Critical review	Year 3
EC 4.3: Interdisciplinary teamwork					
K	Identify resources, principles of interprofessional collaborative practice, principles of community engagement, referral pathways, support systems relating to CDDB, in clinical and community-based settings	PEoLC IPE Palliative care internship	Lecture Seminar Clinical practice	Written test SOCA	Year 3 Year 5
A	Demonstrate positive collaboration between intra- and inter-department/ institutions, value the position of the family, caregivers and other health professionals in providing EoLC, appreciate needs for a continuum of care	PEoLC IPE CCSA 1 and 2 Palliative care internship	Workshop PBL Clinical practice	Group project SOCA	Year 3 Year 4 Year 5

S	Participate in community programmes, refer dying patients to relevant healthcare providers, link patients and their family to support systems, identify support systems and interdisciplinary teamwork	PEoLC IPE CCSA 1 and 2 Palliative care internship	Service learning Clinical practice	Self-competence assessment Reflective paper	Year 3 Year 4 Year 5
KC 5: Cultural and spiritual competence					
EC 5.1: Beliefs and values					
K	Identify the philosophy, meaning about life, DDB	FoN 1 Religion in Nursing	Lecture Seminar	Written test	Year 1
A	Appreciate different beliefs, values and traditions related to CDDB	Religion in Nursing Psychosocial and cultural issues in nursing CCSA 1 and 2 Palliative care internship	PBL SGD Clinical practice	Written test SOCA	Year 1 Year 2 Year 3 Year 4 Year 5
S	Conduct a spiritual needs assessment of patients and families	PEoLC CCSA 1 and 2 Palliative care internship	Simulation-based learning Clinical practice	OSCE SOCA	Year 1 Year 3 Year 4 Year 5
EC 5.2: Cultural and spiritual awareness					
K	Identify one's own philosophy, religious beliefs, values, and assumptions relating to life and DDB	Religion in Nursing Psychosocial and cultural issues in nursing CCSA 1 and 2 Palliative care internship	Lecture Seminar Clinical practice	Written test SOCA	Year 1 Year 2 Year 3 Year 4 Year 5
A	Aware of principles, values, beliefs and judgements that may intervene in relationships with dying patients and their families	Religion in Nursing Psychosocial and cultural issues in nursing PEoLC CCSA 1 and 2 Palliative care internships	PBL SGD Clinical practice	Written test OSCE SOCA	Year 1 Year 2 Year 3 Year 4 Year 5
S	Maintain self-awareness through reflection in practice Know how to search and utilise available cultural and religious supports	Psychosocial and cultural issues in nursing CCSA 1 and 2 Palliative care internship	Workshop Sharing forum Clinical practice	Reflective paper	Year 2 Year 3 Year 4 Year 5
KC 6: Coping skills					
K	Identify strategies and resources for own personal and professional development	Personality development	Lecture Seminar	Written test	Year 1 Year 5
A	Value the needs and importance of development and self-care, cultivate life-long learning ability	Personality development CCSA 1 and 2 Palliative care internship	Reflective practice Sharing forum Clinical practice	Reflective paper	Year 1 Year 3 Year 4 Year 5
S	Maintain self-care, know how to obtain information and supports to minimise the negative impacts of dying and death exposures	Personality development CCSA 1 and 2 Palliative care internship	Workshop Sharing forum Clinical practice	Reflective paper	Year 1 Year 3 Year 4 Year 5

9.4.2.3 Curriculum implementation, evaluation and sustainability

Based on the curriculum mapping results, content related to DDB has been delivered in the intended curriculum from the first year of study onwards. Within the new intended curriculum, these subjects culminate with the delivery of PEoLCE in the advanced stages of training (years 3 and 5). The findings of this study correspond with the spiral curriculum approach, in which students' learning retention is maintained so that their knowledge and skills are gradually improved. As stated by Miller (2010), the spiral approach supports teaching and learning from simple to more complex issues, and thus facilitates the achievement of key and enabling competencies by students.

The integration of the ENSURE elements in the context of classroom, clinical and community-based learning may be guided using conceptual models or theories relevant to CDDB. For example, the Roy Adaptation Model (RAM), which embraces four components: physiological, self-concept, role function and interdependence. Further research is warranted in relation to what the optimal nursing model may be for underpinning CDDB education in the context of Indonesian nursing.

The findings of the study further indicate the need to develop an interprofessional educational focus on CDDB (see sections 6.3.3.2 and 6.3.3.3). Exploring perceptions and needs towards CDDB from the perspectives of other health professional students would be beneficial to identify common issues for interprofessional education on CDDB at university level (Ellman et al., 2016). Further identification is also warranted of common core competencies in interprofessional education and collaborative practice (WHO, 2010) relating to CDDB. Since Kern's model permits an iterative curriculum process, refining and revalidating the constructed CDDB elements as suggested in this study can therefore be carried out retrospectively. Thus, faculty administrators and nurse educators may revisit steps 3 and 4 (Kern et al., 2009) when developing educational strategies to enable key competencies and meaningful learning outcomes (see section 7.5.2.1). Such a pragmatic methodology offers maximum flexibility and opportunities for faculties to revise curriculum and pedagogy practice, based on institutional needs and stakeholder preferences.

9.4.3 Implications for Research

The inclusion of document reviews and focus group discussions with key participants in this study led to important conceptual findings on elements of the curriculum framework. However, such concepts have not yet been validated, and further research, involving multiple stakeholders representing different national entities and institutions, is required to refine and validate the ENSURE framework. In order to provide a complete picture of how Kern's six-step approach may be used to guide curriculum design, further detail is provided here of the development of phase two (Kern's steps three and four) and phase three (Kern's steps five and six) of the study. For example, adopting a pragmatist stance,

a collaborative longitudinal multi-methods study encompassing action research (AR) could be conducted (Brown, 2016; Lincoln and Guba, 2013) to review, refine and validate the ENSURE elements and to apply those in the new intended curriculum. A detailed description of this proposed process is shown in Figure 9 below.

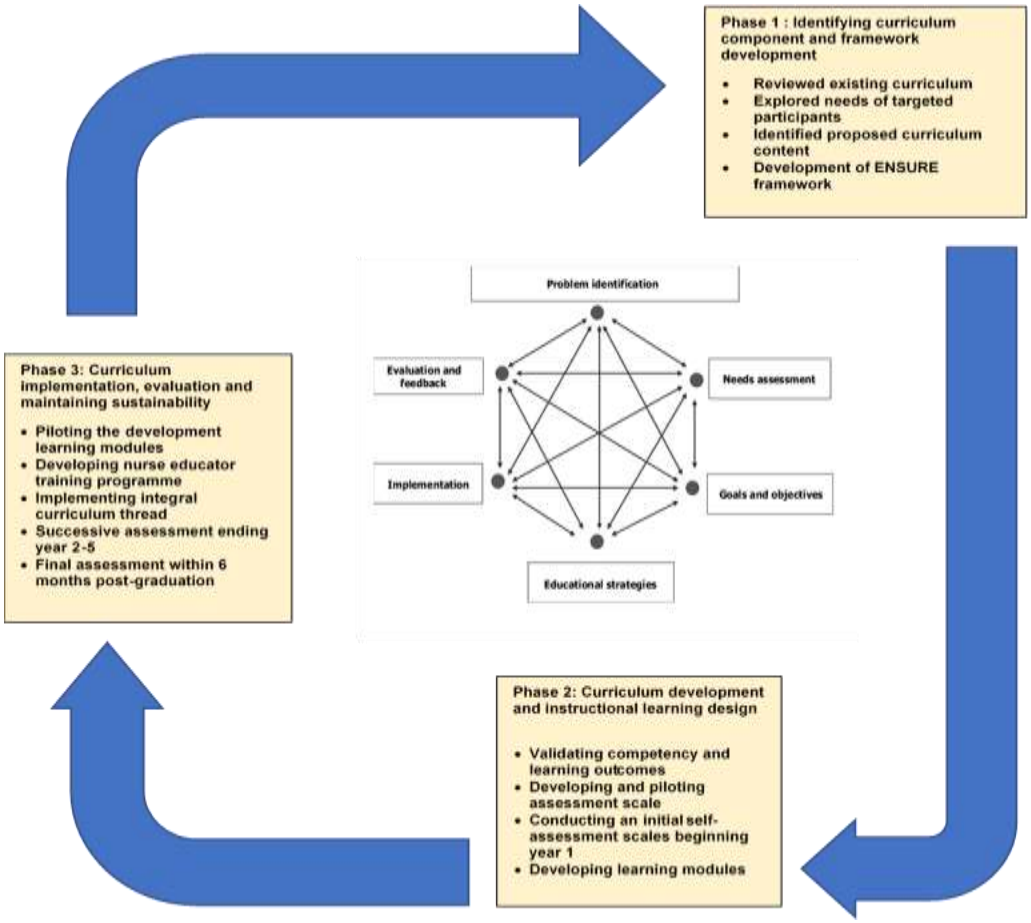

Figure 9: Proposal for a collaborative longitudinal multi-methods study. (Adopted from Kern et al., 2009; Brown, 2016).

Curriculum and instructional learning design is now needed, aimed at reviewing, refining and validating the key competencies, learning outcomes and pedagogical strategies (see sections 7.5.1.1 and 7.5.1.2). The effectiveness of teaching and learning about CDDB can then be evaluated. A negotiated, collaborative and participative team approach will be needed (Brown, 2016), involving consultation with students, educators, graduates and practitioners. This will enable the latter stakeholders to contribute to the design of instructional learning and to validate CDDB narratives and other resources for use in the educational process. Such approaches are consistent with the use of a pragmatist approach, informed by sociocultural and transformative learning principles.

The findings of this study further suggest that CDDB should not be ignored due to technical-rational and fragmented approaches to care. Nurse educators should

transform their frames of references in teaching and learning about CDDB, by involving ontology and epistemology of nursing practice. To this aim, more research is needed about how to counter powers, hierarchical structures and socio-political domination in the integration of the ENSURE framework into the intended curriculum and in the evaluation of curriculum implementation, in the context of classroom, clinical and community-based learning discourses.

9.5 Recommendations

The outcomes of this research have potentially broad implications. The key theoretical and practical recommendations for nurse educators and curriculum developers are described below.

9.5.1 Applying innovation in teaching and learning about CDDB

The findings of this study confirmed those of Cavaye et al. (2015) and Johnson (2011), that a crowded curriculum, limited pedagogy and teaching strategies, and a lack of clinical learning experiences all constrain students' learning in CDDB. Such constraints may be managed as follows:

- Embedding EoLCE as supplementary learning in the pre-clinical orientation programme, or as extra-curricular activities (see section 5.5.2).

- Using digital technologies in teaching and learning, such as online and blended learning methods to improve the knowledge and attitudes of students and nurses in the area of dying and death (Ellman et al., 2013; Kavanaugh et al., 2013; Wochna et al., 2014; Bailey et al., 2017). Such methods can also support internationalisation in nursing education, learner-centred approaches, problem-solving methods and social interactions during the teaching and learning process (Bailey et al., 2017).

- Developing specific learning modules that can be tested to maximise the taught content. For example, Pfitzinger et al. (2015) developed a two-hour end of life simulation-based learning scenario, which addressed aspects of communication, interprofessional collaboration, pain management, symptom management, loss, grief and bereavement, and final hours of life.

- Developing a service-learning programme attached to community nursing practice, or student field work within relevant institutions (e.g. primary healthcare centres, aged care, home care nursing, community shelters and NGOs) (see section 6.3.3.5). Such potential strategies could be further developed, tested and implemented, with the aim of providing educational experiences that are effective, efficient and consistent for all nursing students.

9.5.2 Promoting supportive and facilitative environments

A supportive learning environment forms the building block of student engagement in higher education. Supportive learning environments require provision of social and emotional support, clinical supervision and mentoring, and availability of educational resources and access. In this study, the presence of power dynamics in student-teacher relationships was clearly evident. Development of agency on the part of students was limited where current structures were not found to be supportive. Greater support could be provided by:

- Providing a standardised curriculum guide for nurse educators and faculty administrators, including a summary of themes and subthemes, with good facilitation and meaningful access.

- Providing social and emotional support during clinical placements, e.g. via briefing/debriefing activities and grief counselling, to minimise the psychosocial burden of students (Gallagher et al., 2014; Poultney et al., 2014; Lippe et al., 2015; Lewis et al., 2016).

- Faculty members and clinical instructors need to strengthen their roles in improving their counselling methods in order to manage distress during pre-clinical and clinical learning.

- Improving learning resources and accesses to materials for teaching and learning in EoLC, including research publications, is similarly essential, although issues may exist in relation to language barriers when accessing international publications. Developing EoLCE materials and training programmes aligned with the national language therefore warrants further work.

9.5.3 Establishing professional development programmes

The findings of this study indicated that both students and nurse educators lacked knowledge and skills in caring for dying patients and their families in hospital. These issues could be countered by:

- Developing core competencies in CDDB through panel consensus that involves users, educators, practitioners and policy makers.

- Designing appropriate content and pedagogy strategies following characteristics of nurses and levels of acquisition of skills in CDDB (Benner, 1994).

- Providing written knowledge and standardised operating procedures for novice nurses. For example, end of life assessment tools, ethical and decision-making

guidance, effective communication and protocols for breaking bad news, pathways for care of the dying, protocols for care of the deceased body, and guidelines for bereavement care.

- Developing training programmes for advance beginner and competent teaching staff and clinical instructors on methods of teaching and coaching, in order to improve clinical supervision and mentoring programmes in CDDB (Benner, 1994; McAllister, 2017; Walker-Reed, 2016).

- Enhancing nurse educators' professional competencies in CDDB, which may be facilitated through 'train the trainer' programmes in EoLCE (Gamondi et al., 2013b; Takenouchi, 2018) and via visiting professors, clinical preceptor training, and expert consultation (Bassah, 2017).

9.5.4 Improving interprofessional collaboration and partnerships

Strengthening partnerships between academic, practice, and community dimensions has become an influential agenda in the process of curriculum development and implementation. This requires active collaboration with partner institutions, in this case, teaching hospitals and other satellite institutions that include the following activities:

- Users' involvement in refining and validating the curriculum content, as well as evaluating the performance of students and graduates.

- Generating a scientific research forum to facilitate the identification and development of palliative care and end of life care as a philosophy and approach that complies with academic and healthcare practice implications for policies in Indonesia.

- Creating an interprofessional end of life care education programme for undergraduate health professional students at university level.

- Developing a scientific forum, in collaboration with other nursing schools, professional organisations and NGOs, relevant to palliative care and EoLC practice and education.

- Establishing an interdisciplinary research group to identify needs in the area of EoLC, in order to support the development and improvement of healthcare policies and regulations.

9.6 Conclusion

The purpose of this study was to develop an empirically- and theoretically-driven curriculum framework of care of the dying, dead and bereaved for undergraduate nursing students, by applying multimethods study to answer the research questions.

Overall, the following conclusions can be made based on the findings of this study. The emergent findings from a scoping review of undergraduate nursing curricula in Asian regions indicated the diversity and complexity of EoLCE strategies, and highlighted a lack of curriculum evaluation studies, with consequent difficulties for determining the best evidence-based curriculum for students. Findings recommended that nursing educational institutions should conduct needs assessments prior to developing the curriculum, in order to identify barriers and challenges relating to CDDB within nursing practice and education.

The findings from interviews conducted with students and nurse educators revealed critical issues representing barriers, challenges and facilitators when facing dying and death in a learning environment. Students and nurse educators were aware of the importance of CDDB as a meaningful practice and learning experience. Students' engagement with dying and death was challenged by the presence of intangible practice and learning, and teachers' lack of professional capacity to support their engagement in learning. Hence, the development of professional attributes and skills for practice, establishment of professional relationships, support and facilitation towards professional agency, and negotiation of curriculum content and pedagogy practice are all needed in promoting CDDB within professional nursing practice. Findings recommended that current teaching and learning processes should be evaluated, and relevant content should be identified and embedded in the undergraduate curriculum.

Findings from the curriculum mapping exercise demonstrated that dying and death have been formally acknowledged as concepts in undergraduate nursing education in Indonesia, but that unstructured teaching and learning activities, compounded by an absence of intended learning outcomes, make CDDB a 'hidden curriculum', which remains silent at the surface level. Accordingly, findings from the focus group discussion suggested fundamental aspects that should be included in the curriculum and learning instructional design, including enabling key competency and meaningful practice, negotiating curriculum and pedagogical strategies, and promoting support and facilitation.

Findings from the last stage of the study revealed four core elements, labelled 'ENSURE', as the curriculum framework of CDDB. The ENSURE framework is proposed here as the curriculum thread for integration into the existing undergraduate

nursing programme, via multiple ways of knowing and adoption of socio-cultural and transformative-based learning principles.

This qualitative multimethods study is the first known empirical study to explore perceptions and experiences of care of the dying from the perspectives of stakeholders in higher nursing education and healthcare. This topic has not yet been covered in the majority of professional health education systems in developing countries. This study has further generated a framework as a curriculum innovation to improve the current content and pedagogical approaches relating to CDDB in undergraduate nursing programmes. The findings highlight the importance of evidence-based and culturally-sensitive approaches towards higher nursing education innovation. Such a framework has the potential to inform and support further refinement of the new national curriculum of undergraduate nursing education in Indonesia. The findings also provide an in-depth understanding of contextual factors within this area, which are highly relevant in implementing policy improvements and innovations in local health, professional education and health service delivery contexts. A future direction for implementation and evaluation projects has therefore been suggested as part of the future research agenda. The planned research programmes have the potential to contribute further to knowledge about curriculum content and pedagogy in the context of EoLC and undergraduate nursing curriculum development. The findings may also have several implications in terms of policy recommendations, for example, in influencing standards of national accreditation for undergraduate nursing programmes.

In summary, in terms of nursing students and the nursing profession overall, the findings of this study have generated clear expectations towards enhancing educational preparation for nursing graduates to provide excellent end of life care.

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Appendix A. Topic Guide for Semi-Structured Interviews with students and nurse educators

Student's interview

1. Background
   - Welcome and thank participants
   - Introduce the interview topics/researchers
   - Confirms the completion of the consent form
   - Personal details: date, years of enrollment, age, gender, race/ethnicity, religion, unit of clinical/community placement
2. Experience with caring for people at the end of life
   - What do you know about the care of the dying? Please describe.
   - Can you tell me about your experiences when caring for people at the end of life is a learning environment?
2. Barriers and challenges when dealing with dying and death
   - Can you tell me about difficulties when caring for people at the end of life in the classroom, clinical or community settings?
   - Are there any missing topics from current learning guides about caring for people at the end of life? Can you tell me more about this, please?
   - Can you tell me any impact of your previous learning experience about the care of the dying towards your current clinical performance? Tell me more about this, please.
3. Facilitators
   - Can you tell me about things that might help you when caring for people at the end of life?
   - What is your thought or idea about how to improve teaching and learning in caring for people at the end of life?
4. Conclusion
   - Summary of what has been conveyed
   - Is there anything else that you want to discuss teaching and learning in care of the dying, dead and bereaved in this Faculty?
   - Thank the participant

Nurse Educators' Interview

1. Background
   - Welcome and thank participants
   - Introduce the interview topics/researchers
   - Confirms the completion of the consent form
   - Personal details: date, age, gender, race/ethnicity, religion, educational background, working unit, number of years working in the nursing practice, number of years working in the faculty/instructor, number of years working as the nurse educator.
2. Experience with the care of the dying, dead and bereaved
   - What do you know about the care of the dying? Please describe.
   - Can you tell me about your experiences when caring for people at the end of life is a learning environment?
   - Can you describe your role in teaching about how to caring people at the end of life in the classroom, clinical or community settings?
2. Barriers and challenges when dealing with dying and death
   - Can you tell me about your difficulties when teaching and supervising students dealing with the caring for people at the end of life in the classroom, clinical or community settings?
   - Are there any missing topics from current curriculum regarding caring for people at the end of life in this Faculty? Can you tell me more about this, please?
   - Can you tell me any impact of your previous experience about caring for people at the end of life towards your current teaching role? Tell me more about this, please.
3. Facilitators
   - Tell me about things might help you when teaching and supervising students in caring for people at the end of life.
   - Can you tell me about your thoughts or ideas about how to improve teaching and learning about the end of life care?
4. Conclusion
   - Summary of what has been conveyed
   - Is there anything else that you want to tell me about teaching about dying, death and bereavement in a learning environment?
   - Thank the participant

Appendix B: Focus Group Anticipatory Guidance

Focus Group Anticipatory Guidance

FGD	:
Participant number	:
Time	:
Location/Address	:

General Objective

This study aims to confirm findings of curriculum component focuses on care of the dying, dead and bereaved for undergraduate nursing students in the Faculty of Nursing Universitas Padjadjaran.

Specific Objectives

Participants are expected to:

1. Provide their opinion and feedback regarding competencies must be achieved by undergraduate nursing students related to care of the dying, dead and bereaved both in academics and clinical learning situation.
2. Provide their opinion and feedback regarding any missing aspects should be embedded in the curriculum.
3. Provide their ideas and thoughts regarding the ways of delivery in undergraduate nursing education.
4. Provide their ideas regarding barriers and facilitators to implement curriculum focuses on care of the dying, dead and bereaved in the university setting.

Opening question

1. Do you think these curricular contents are relevant to care of the dying, dead and bereaved for undergraduate nursing students?
2. Are there any missing aspects from those curricular content?
3. Can you think some way to deliver that component for undergraduate nursing students?
4. What do you think could be done to evaluate the student's achievement focuses on care of the dying, dead and bereaved in both academics and clinical learning settings?
5. What do you think about barriers and its facilitators regarding the curriculum implementation focuses on care of the dying, dead and bereaved for undergraduate nursing education?

1

Appendix C: Informed Consent Form for Students

CONSENT FORM

Final version 2.0: 02 October 2017

Title of Study: Care of the Dying, Dead and Bereaved: Developing the Curriculum for Undergraduate Nursing Students of a Public University in Indonesia

REC ref: OVSa12072016

Name of Researcher: Hana Rizmadewi Agustina, Christine Moffatt, Sarah Goldberg, Bridget Johnston

Name of Participant:

Please initial box

I confirm that I have read and understood the information sheet version number ……dated..... for the above study and have had the opportunity to ask questions.	☐
I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason.	☐
I understand that relevant sections of my data collected in the study may be looked at by the research group and by other responsible individuals for monitoring and audit purposes.	☐
I give permission for these individuals to have access to these records and to collect, store, analyse and publish information obtained from my participation in this study. I understand that my personal details will be kept confidential.	☐
I understand that the interview/focus group* will be audio/video* recorded using an MP4 recorder and that anonymous direct quotes from the interview may be used in the study reports.	☐
I understand that all data will be anonymous and confidential with the exception of information being revealed during the interview which is of concern and may need reporting i.e. potential risks to another person or to myself and members of the research team.	☐
I agree to maintain the confidentiality of focus group discussions.	☐
I understand that information about me recorded during the study will be kept in a secure database. If the data is transferred is will be made anonymous. Data will be kept for 7 years after the study has ended and then securely destroyed.	☐
I agree to take part in the above study.	☐

Name of Participant Date Signature

Name of Person taking consent Date Signature

2 copies: 1 for the participant, 1 for the project notes

Appendix D: Information Sheet for students

The University of Nottingham
UNITED KINGDOM · CHINA · MALAYSIA

Information participant sheet for students

Title of Project:
Care of the dying, dead and bereaved: Developing the curriculum for undergraduate nursing students in a public university in Indonesia

Name of Investigators:
Hana Rizmadewi Agustina, postgraduate student (PhD in Nursing Studies), School of Nursing, University of Nottingham

Academic supervisors:
1. Professor Christine Moffatt, Professor of Clinical Nursing, School of Health Sciences, University of Nottingham
2. Dr Sarah Goldberg, Associate Professor in Older Persons Care, School of Health Sciences, University of Nottingham
3. Professor Bridget Johnston, Florence Nightingale Foundation Chair of Clinical Nursing Practice Research, School of Medicine, Dentistry & Nursing, College of Medical, Veterinary & Life Sciences, University of Glasgow

Title of Project:

Care of the dying, dead and bereaved: Developing the curriculum for undergraduate nursing students in a public university in Indonesia

Name of Investigators:

Hana Rizmadewi Agustina, postgraduate student (PhD in Nursing Studies),

School of Nursing, University of Nottingham

Academic supervisors:

Professor Christine Moffatt, Professor of Clinical Nursing, School of Health Sciences, University of Nottingham

Dr Sarah Goldberg, Associate Professor in Older Persons Care, School of Health Sciences, University of Nottingham

Professor Bridget Johnston, Florence Nightingale Foundation Chair of Clinical Nursing Practice Research, School of Medicine, Dentistry & Nursing, College of Medical, Veterinary & Life Sciences, University of Glasgow

Invitation

You have been invited to take part in a research study. Before you decide whether to take part it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with friends and relatives if you wish to. Ask us if there is anything that is not clear or if you would like more information. Please take time to decide whether you wish to take part or not. If you decide to take part you may keep this leaflet for future reference.

Why are you doing this study?

Nursing students will experience caring for dying patients, dead and bereaved service users during their clinical practice in Indonesia, but such aspects of care have traditionally been neglected. The provision of proper education in these areas is essential to improve the quality of care for patients and their families, as well as to prepare nurses to manage the negative impacts of caring these people. Embedding care of the dying, dead and bereaved within the pre-registration nursing curriculum can be viewed as a solution to prepare students to become compassionate practitioners in the future. However, there is no consensus on how much education should be delivered in Indonesia. Thus, the overall

aim of this study is to develop a new curriculum that incorporates care of the dying for undergraduate nursing education in the Indonesian context.

The duration of the study: 1 year

What does the study involve?

The study will involve undergraduate students in years 4 and 5 who agree to participate in interviews by providing their email address and who return the response slip. The chosen respondents will be asked for individual interview sessions. I will take apart as an interviewer during the interview process.

Why have you been chosen?

You have chosen because you are a nursing student at FoN Unpad that enrolled in the final years of study and have been exposed to clinical learning situations.

Where will the research take place?

The research will take place in the Faculty of Nursing Unpad, either in the main or the branch campus. Furthermore, the researcher will use a private room to conduct an individual interview based on your convenience.

Do you have to take part?

It is up to you to decide whether or not to take part. If you do decide to take part, you will be given this information sheet to keep and be asked to sign a consent form. If you decide to take part you are still free to withdraw at any time and without giving a reason.

What do I have to do?

You have to indicate your consent by signing the consent form and provide your email address for further correspondence. The form should be sent to the head of the nursing programme in your faculty.

What are the possible disadvantages and risks of taking part?

The interview could evoke painful experiences and unpleasant memories for you. If this happens, please ask the researcher to stop the interview. You can then think about whether you wish to continue or not.

What are the possible benefits of taking part?

There are no direct benefits for you by taking part in the study; however, the results will improve the quality of undergraduate education regarding palliative and end of life care in FoN Unpad.

Expenses and inconvenience allowance

The researcher will provide merchandise that costs a maximum of about 50,000 IDR (£2) will be given to each student as a token of appreciation after the interview is finished.

What if something goes wrong? /Whom can I complain to?

In case you have any concerns about any aspect of this research or your participation, you can initially contact the researcher **Hana Rizmadewi Agustina**. However, if you have further questions or complaints, please contact my main advisor **Professor Karen Cox**: christine.moffatt@nottingham.ac.uk. You can also contact the head of your nursing programme as well.

Will my taking part in this study be kept confidential?

All information which is collected about you during the course of the research will be kept on a password-protected database accessible only to the research team, and which is strictly confidential. Any information about you which leaves the research unit will have your name and address removed so that you cannot be recognised from it.

What happens if I want to stop participating in the study?

Your participation is voluntary and you are free to withdraw at any time, without giving any reason. However, the data that you have already provided will be used in the final analysis. You can inform the researcher at any time that you do not want to be involved in the group process.

What will happen to the results of the research study?

The results will inform the best learning content and teaching strategy to deliver care of the dying, the dead and bereaved curriculum in Indonesian undergraduate nursing education. The results will be written as a doctoral thesis and published in journal articles and conferences. No names and addresses or any personally identifying details will be used in the dissemination of the results.

Who is organising and funding the research?

The Directorate General of Higher Education of Indonesia is funding this study. This is being undertaken as a partial fulfilment for an educational qualification (PhD) at the University of Nottingham, UK.

Who has reviewed the study?

This study has been reviewed by the Ethics Committee of the Faculty of Medicine and Health Sciences, University of Nottingham, UK.

Contact for Further Information

Hana Rizmadewi Agustina

Faculty of Nursing Universitas Padjadjaran

Universitas Padjadjaran

Jl. Raya Bandung-Sumedang km 21
Indonesia 45363

Ph: +6222 77954497 Fax: +6222 7795497

Mobile: +6281214148757

Email: ntxhra@nottingham.ac.uk

Thank you for reading this.

Reply Slip

I would like to be involved as a participant in the **interview** of the study entitled 'Care of the Dying, Dead, and Bereaved: Developing the Curriculum for Undergraduate Nursing Students of a Public University in Indonesia'.

For future arrangement, please contact me using details as follows:

Email address: .....

Phone number: .....

*** Please circle either one or two of the offered procedures**

Note: Please return this slip to the academic or clinical course coordinators or email to **ntxhra@nottingham.ac.uk.**

Appendix E: Informed Consent Form for Nurse Educators and Practitioners

CONSENT FORM

Final version 2.0: 02 October 2017

Title of Study: Care of the Dying, Dead and Bereaved: Developing the Curriculum for Undergraduate Nursing Students of a Public University in Indonesia

REC ref: OVSa12072016

Name of Researcher: Hana Rizmadewi Agustina, Christine Moffatt, Sarah Goldberg, Bridget Johnston

Name of Participant:

Please initial box

I confirm that I have read and understood the information sheet version number ……dated…… for the above study and have had the opportunity to ask questions.	☐
I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason.	☐
I understand that relevant sections of my data collected in the study may be looked at by the research group and by other responsible individuals for monitoring and audit purposes.	☐
I give permission for these individuals to have access to these records and to collect, store, analyse and publish information obtained from my participation in this study. I understand that my personal details will be kept confidential.	☐
I understand that the interview/focus group* will be audio/video* recorded using an MP4 recorder and that anonymous direct quotes from the **interview and/or focus group discussion** may be used in the study reports.	☐
I understand that all data will be anonymous and confidential with the exception of information being revealed during the interview which is of concern and may need reporting i.e. potential risks to another person or to myself and members of the research team.	☐
I agree to maintain the confidentiality of focus group discussions.	☐
I understand that information about me recorded during the study will be kept in a secure database. If the data is transferred is will be made anonymous. Data will be kept for 7 years after the study has ended and then securely destroyed.	☐
I agree to take part in the above study.	☐

Name of Participant Date Signature

Name of Person taking consent Date Signature

2 copies: 1 for the participant, 1 for the project notes

Appendix F: Information Sheet for Nurse educator/Practitioners

The University of Nottingham
UNITED KINGDOM • CHINA • MALAYSIA

Information participant sheet for Nurse educators/Practitioners

Title of Project:
Care of the dying, dead and bereaved: Developing the curriculum for undergraduate nursing students in a public university in Indonesia

Name of Investigators:
Hana Rizmadewi Agustina, postgraduate student (PhD in Nursing Studies), School of Nursing, University of Nottingham

Academic supervisors:
1. Professor Christine Moffatt, Professor of Clinical Nursing, School of Health Sciences, University of Nottingham
2. Dr Sarah Goldberg, Associate Professor in Older Persons Care, School of Health Sciences, University of Nottingham
3. Professor Bridget Johnston, Florence Nightingale Foundation Chair of Clinical Nursing Practice Research, School of Medicine, Dentistry & Nursing, College of Medical, Veterinary & Life Sciences, University of Glasgow

Invitation

You have been invited to take part in a research study. Before you decide whether to take part, you need to understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with friends and relatives if you wish to. Ask us if there is anything that is not clear or if you would like more information. Please take time to decide whether you wish to take part or not. If you decide to take part, you may keep this leaflet for future reference. Thank you for reading this.

Why are you doing this study?

Nursing students will experience caring for dying patients, dead and bereaved during their clinical practice in Indonesia. Thus, the provision of such proper education is essential to improve the quality of care for patients and their families, as well as to prepare them to manage the negative impacts of caring for these people. Embedding care of the dying, dead and bereaved within the pre-registration nursing curricula can be viewed as a solution to prepare students to become compassionate practitioners in the future. However, there is no consensus on how much education should be delivered in Indonesia. Thus, the overall aim of this study is to develop a new curriculum of care of the dying for undergraduate nursing education in the Indonesian context.

The duration of the study: 1 year

What does the study involve?

The study will involve faculty staff members, clinical instructors and experts (with a minimum of one year's participation in nursing education) requested to participate in interviews and focus group discussion voluntarily; those who agree will provide their email address and return the response slip.

The chosen respondents of students and nurse educators will be asked for an individual interview session. The chose experts will be asked to participate in the focus group discussion. I will take apart as an interviewer and facilitator during the group process.

Why have you been chosen?

You have chosen because you are a nursing educator employed by FoN Unpad with one year's experience of teaching and/or doing clinical supervision.

Where will the research take place?

The research will take place in the Faculty of Nursing, either in the main or in branch campuses. Furthermore, the researcher will use a private room to conduct an individual interview based on your convenience.

Do you have to take part?

It is up to you to decide whether or not to take part. If you do decide to take part, you will be given this information sheet to keep and be asked to sign a consent form. If you decide to take part, you are still free to withdraw at any time and without giving a reason.

What do I have to do?

You have to indicate your consent by signing the consent form and provide your email address for further correspondence. The form should be sent to the head of the nursing programme in your faculty.

What are the possible disadvantages and risks of taking part?

The interview could evoke painful experiences and unpleasant memories for you. If this happens, please ask the researcher to stop the interview. You can then think about whether you wish to continue or not.

What are the possible benefits of taking part?

There are no direct benefits for you by taking part in the study; however, the results will improve the quality of undergraduate education regarding palliative and end of life care in FoN Unpad.

Expenses and inconvenience allowance

The researcher will allocate transportation costs for nurse educator participants involved in an interview and/or focus groups discussion. Each participant will receive a maximum of about 100,000 IDR (approximately £5) per procedure as compensation for their time.

What if something goes wrong? /Whom can I complain to?

In case you have any concerns about any aspect of this research or your participation, you can initially contact the researcher **Hana Rizmadewi Agustina**. However, if you have further questions or complaints, please contact my main advisor **Professor Christine Moffatt:** christine.moffatt@nottingham.ac.uk. You can also contact the head of your nursing programme as well.

Will my taking part in this study be kept confidential?

All information which is collected about you during the course of the research will be kept on a password-protected database accessible only to the research team, and which is strictly confidential. Any information about you which leaves the research unit will have your name and address removed so that you cannot be recognised from it.

What happens if I want to stop participating in the study?

Your participation is voluntary, and you are free to withdraw at any time, without giving any reason. However, the data that you have already provided will be used in the final analysis. You can inform the researcher at any time that you do not want to be involved in the group process.

What will happen to the results of the research study?

The results will inform the best learning content and teaching strategy to deliver care of the dying, the dead and bereaved curriculum in Indonesian undergraduate nursing education. The results will be written as a doctoral thesis and published in journal articles and conferences. No names and addresses or any personally identifying details will be used in the dissemination of the results.

Who is organising and funding the research?

The Directorate General of Higher Education of Indonesia is funding this study. This is being undertaken as a partial fulfilment for an educational qualification (PhD) at the University of Nottingham, UK.

Who has reviewed the study?

This study has been reviewed by the Ethics Committee of the Faculty of Medicine and Health Sciences, University of Nottingham, UK.

Contact for Further Information

Hana Rizmadewi Agustina

Faculty of Nursing Universitas Padjadjaran

Universitas Padjadjaran

Jl. Raya Bandung-Sumedang km 21
Indonesia 45363

Ph: +6222 77954497 Fax: +6222 7795497

Mobile: +6281214148757

Email: ntxhra@nottingham.ac.uk

Thank you for reading this

Reply Slip

I would like to involve as a participant of **interview/focus groups*** in a study entitled 'Care of the Dying, Dead, and Bereaved: Developing Curriculum for Undergraduate Nursing Students of a Public University in Indonesia'.

For future arrangement, please contact me using details as follows:

Email address:.....

Phone number: .....

*** Please circles either one or two of offered procedures**

Note: Please return this slip to the clinical and course coordinators or email to **ntxhra@nottingham.ac.uk**

Appendix G: Poster (A1 size) and Flyer (A5 size)

Appendix H. Research Permission Letter

MINISTRY OF RESEARCH, TECHNOLOGY AND HIGHER EDUCATION
FACULTY OF NURSING
UNIVERSITAS PADJADJARAN
Jl. Raya Bandung- Sumedang Km. 21 Jatinangor – Sumedang 45363
Phone/Fax.(62-22) 7795596, 7796647 email : keperawatan@unpad.ac.id

No. Letter : 2310/UN6.L/TU/2016 Bandung, 02 June 2016

University of Nottingham Medical School Ethics Committee
Faculty of Medicine and Health Sciences
University of Nottingham
Medical School Queen's Medical Centre Nottingham,
NG7 2UH

RE:
Hana Rizmadewi Agustina
Professor Karen Cox (Supervisor 1)
Professor Christine Moffatt (Supervisor 2)
Professor Bridget Johnston (Supervisor 3)
"Care of the Dying, Dead and Bereaved: Developing Curriculum for Undergraduate Nursing Students in a Public University in Indonesia"

To: UoNMSEC

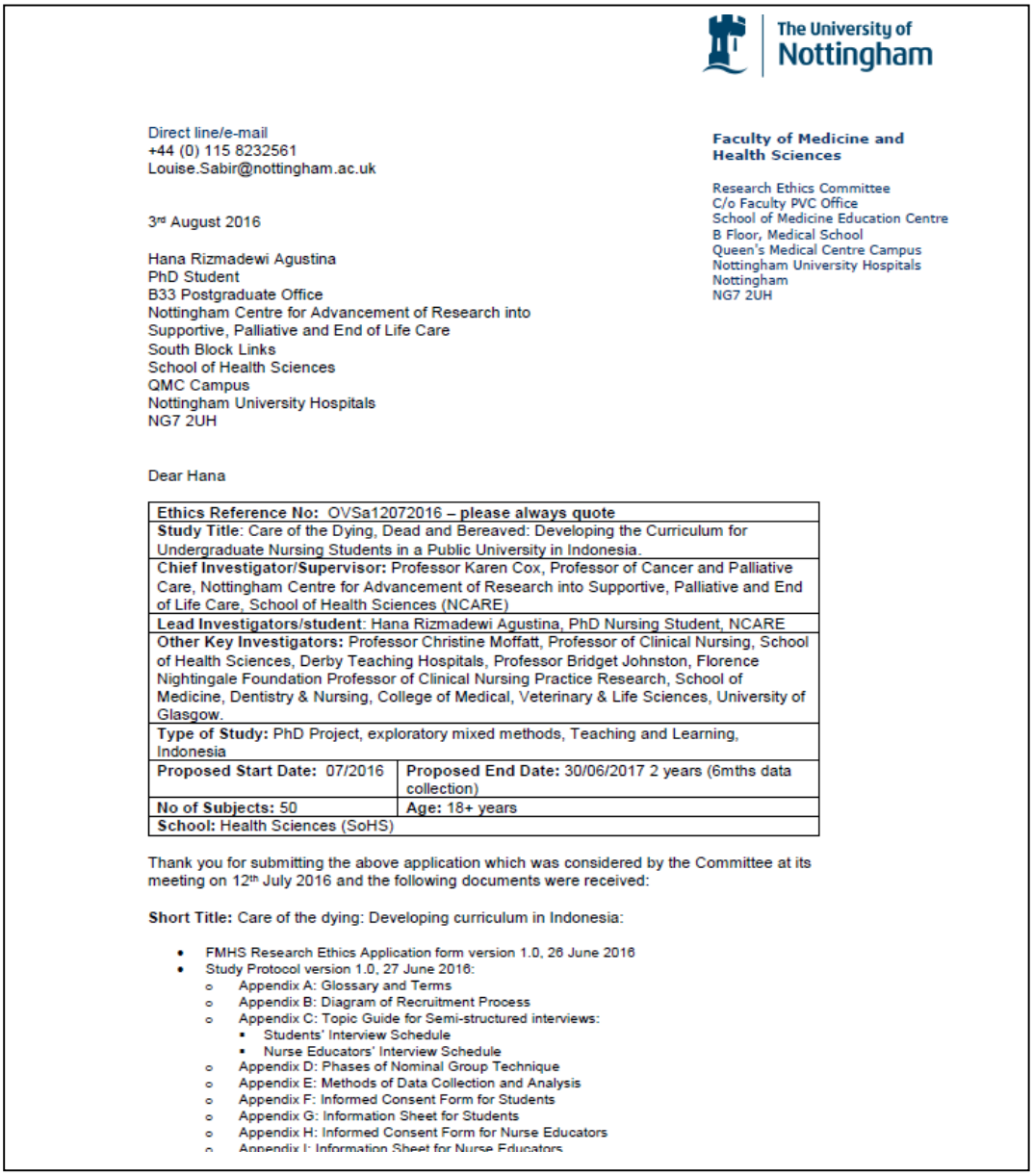
This letter is to convey that we have reviewed the proposed research study being conducted by Hana Rizmadewi Agustina intended to conduct research at Faculty of Nursing, Universitas Padjadjaran, Bandung Indonesia and find that "Care of the Dying, Dead and Bereaved: Developing Curriculum for Undergraduate Nursing Students in a Public University in Indonesia" is acceptable. We give permission for the above investigators to conduct research at this site. If you have any questions regarding site permission, please contact: Dr. Kusman Ibrahim at dekanfkep@unpad.ac.id cc kusman_ibrahim@yahoo.com.

Sincerely yours

Kusman Ibrahim, BSN, RN, MNS,PhD
Dean

Faculty of Nursing Universitas Padjadjaran
Jl. Raya Bandung- Sumedang km 21
West Java - 45363
INDONESIA

Appendix I. Ethics Approval



The University of Nottingham

Direct line/e-mail
+44 (0) 115 8232561
Louise.Sabir@nottingham.ac.uk

Faculty of Medicine and Health Sciences

Research Ethics Committee
C/o Faculty PVC Office
School of Medicine Education Centre
B Floor, Medical School
Queen's Medical Centre Campus
Nottingham University Hospitals
Nottingham
NG7 2UH

3rd August 2016

Hana Rizmadewi Agustina
PhD Student
B33 Postgraduate Office
Nottingham Centre for Advancement of Research into Supportive, Palliative and End of Life Care
South Block Links
School of Health Sciences
QMC Campus
Nottingham University Hospitals
NG7 2UH

Dear Hana

Ethics Reference No: OVSa12072016 – **please always quote**	
Study Title: Care of the Dying, Dead and Bereaved: Developing the Curriculum for Undergraduate Nursing Students in a Public University in Indonesia.	
Chief Investigator/Supervisor: Professor Karen Cox, Professor of Cancer and Palliative Care, Nottingham Centre for Advancement of Research into Supportive, Palliative and End of Life Care, School of Health Sciences (NCARE)	
Lead Investigators/student: Hana Rizmadewi Agustina, PhD Nursing Student, NCARE	
Other Key Investigators: Professor Christine Moffatt, Professor of Clinical Nursing, School of Health Sciences, Derby Teaching Hospitals, Professor Bridget Johnston, Florence Nightingale Foundation Professor of Clinical Nursing Practice Research, School of Medicine, Dentistry & Nursing, College of Medical, Veterinary & Life Sciences, University of Glasgow.	
Type of Study: PhD Project, exploratory mixed methods, Teaching and Learning, Indonesia	
Proposed Start Date: 07/2016	**Proposed End Date:** 30/06/2017 2 years (6mths data collection)
No of Subjects: 50	**Age:** 18+ years
School: Health Sciences (SoHS)	

Thank you for submitting the above application which was considered by the Committee at its meeting on 12th July 2016 and the following documents were received:

Short Title: Care of the dying: Developing curriculum in Indonesia:

- FMHS Research Ethics Application form version 1.0, 26 June 2016
- Study Protocol version 1.0, 27 June 2016:
  - Appendix A: Glossary and Terms
  - Appendix B: Diagram of Recruitment Process
  - Appendix C: Topic Guide for Semi-structured interviews:
    - Students' Interview Schedule
    - Nurse Educators' Interview Schedule
  - Appendix D: Phases of Nominal Group Technique
  - Appendix E: Methods of Data Collection and Analysis
  - Appendix F: Informed Consent Form for Students
  - Appendix G: Information Sheet for Students
  - Appendix H: Informed Consent Form for Nurse Educators
  - Appendix I: Information Sheet for Nurse Educators

The University of Nottingham

- Appendix J: Poster (A1 Size) and Flyer (A5 Size)
- Appendix K: Research Permission Letter no: 2310/UN6.L/TU/2016, dated 02 June 2016, Faculty of Nursing, Universitas Padjadjaran West Java, Indonesia

These have been reviewed and are satisfactory and the study is approved.

Approval is given on the understanding that the conditions set out below are followed:

1. A Favourable opinion is given on the understanding that all appropriate ethical and regulatory permissions are respected and followed in accordance with all local laws of the country in which the study is being conducted and those required by the host organisation/s involved.

2. You must follow the protocol agreed and inform the Committee of any changes using a notification of amendment form (please request a form).

3. You must notify the Chair of any serious or unexpected event.

4. This study is approved for the period of active recruitment requested. The Committee also provides a further 5 year approval for any necessary work to be performed on the study which may arise in the process of publication and peer review.

5. An End of Project Progress Report is completed and returned when the study has finished (Please request a form).

Yours sincerely

pp

Professor Ravi Mahajan
Chair, Faculty of Medicine & Health Sciences Research Ethics Committee

KEMENTERIAN RISET, TEKNOLOGI DAN PENDIDIKAN TINGGI
UNIVERSITAS PADJADJARAN FAKULTAS KEDOKTERAN
KOMISI ETIK PENELITIAN KESEHATAN
HEALTH RESEARCH ETHICS COMMITTEE

Jl. Prof. Eyckman No. 38 Bandung 40161
Telp. & Fax. 022-2038697 email: kepk.fk.unpad@gmail.com

No. Reg.: 0616090991

PERSETUJUAN ETIK
ETHICAL APPROVAL

No: 1065 /UN6.C1.3.2/KEPK/PN/2016

Komisi Etik Penelitian Kesehatan Fakultas Kedokteran Universitas Padjadjaran Bandung, dalam upaya melindungi hak asasi dan kesejahteraan subjek penelitian kesehatan dan menjamin bahwa penelitian yang menggunakan formulir survei/registrasi/surveilens/Epidemiologi/Humaniora/Sosial Budaya/Bahan Biologi Tersimpan/Sel Punca dan non klinis lainnya berjalan dengan memperhatikan implikasi etik, hukum, sosial dan non klinis lainnya yang berlaku, telah mengkaji dengan teliti proposal penelitian berjudul:

The Health Research Ethics Committee Faculty of Medicine Universitas Padjadjaran Bandung, in order to protect the rights and welfare of the health research subject, and to guaranty that the research using survey questionnaire/registry/surveillance/epidemiology/humaniora/social-cultural/archived biological materials/stem cell/other non clinical materials, will carried out according to ethical, legal, social implications and other applicable regulations, has been throughly reviewed the proposal entitled:

"*CARE OF THE DYING, DEAD, AND BEREAVED: DEVELOPING CURRICULUM FOR UNDERGRADUATE NURSING STUDENTS OF A PUBLIC UNIVERSITY IN INDONESIA*"

Nama Peneliti Utama *Principal Researcher*	:	Hana Rizmadewi Agustina
Pembimbing/Peneliti Lain *Supervisor/Other Researcher*	:	Professor Karen Cox Professor Christine Moffatt Professor Bridget Johnston
Nama Institusi *Institution*	:	The University of Nottingham United Kingdom

proposal tersebut dapat disetujui pelaksanaannya.
hereby declare that the proposal is approved.

Ditetapkan di : Bandung
Issued in
Tanggal : 10 – 10 – 2016
Date

Ketua,
Chairman,

Prof. Dr. Finman F. Wirakusumah, dr.,SpOG-K
NIP. 19480115 197302 1 001

Keterangan/notes:
Persetujuan etik ini berlaku selama satu tahun sejak tanggal ditetapkan.
This ethical clearance is effective for one year from the due date.
Pada akhir penelitian, laporan pelaksanaan penelitian harus diserahkan ke Komisi Etik Penelitian Kesehatan.
In the end of the research, progress and final summary report should be submitted to the Health Research Ethics Committee.
Jika ada perubahan atau penyimpangan protokol dan/atau perpanjangan penelitian, harus mengajukan kembali permohonan kajian etik penelitian.
If there be any protocol modification or deviation and/or extension of the study, the Principal Investigator is required to resubmit the protocol for approval.
Jika ada kejadian serius yang tidak diinginkan (KTD) harus segera dilaporkan ke Komisi Etik Penelitian Kesehatan.
If there are Serious Adverse Events (SAE) should be immediately reported to the Health Research Ethics Committee

KEMENTERIAN RISET, TEKNOLOGI DAN PENDIDIKAN TINGGI
UNIVERSITAS PADJADJARAN FAKULTAS KEDOKTERAN
KOMISI ETIK PENELITIAN KESEHATAN
HEALTH RESEARCH ETHICS COMMITTEE

Jl. Prof. Eyckman No. 38 Bandung 40161
Telp. & Fax. 022-2038697 email: kepk.fk.unpad@gmail.com

PERPANJANGAN PERSETUJUAN ETIK
CONTINUING ETHICAL APPROVAL

No. Reg.: 0616090991

No: 94 /UN6.C.10/PN/2017

Komisi Etik Penelitian Kesehatan Fakultas Kedokteran Universitas Padjadjaran Bandung, dalam upaya melindungi hak asasi dan kesejahteraan subjek penelitian kesehatan dan menjamin bahwa penelitian yang menggunakan formulir survei/registrasi/surveilens/Epidemiologi/Humaniora/Sosial Budaya/Bahan Biologi Tersimpan/Sel Punca dan non klinis lainnya berjalan dengan memperhatikan implikasi etik, hukum, sosial dan non klinis lainnya yang berlaku, telah mengkaji dengan teliti proposal penelitian berjudul:

The Health Research Ethics Committee Faculty of Medicine Universitas Padjadjaran Bandung, in order to protect the rights and welfare of the health research subject, and to guaranty that the research using survey questionnaire/registry/surveillance/epidemiology/humaniora/social-cultural/archived biological materials/stem cell/other non clinical materials, will carried out according to ethical, legal, social implications and other applicable regulations, has been throughly reviewed the proposal entitled:

"*CARE OF THE DYING, DEAD, AND BEREAVED: DEVELOPING THE CURRICULUM FOR UNDERGRADUATE NURSING STUDENTS OF A PUBLIC UNIVERSITY IN INDONESIA*"

Nama Peneliti Utama *Principal Researcher*	:	Hana Rizmadewi Agustina
Pembimbing/Peneliti Lain *Supervisor/Other Researcher*	:	Professor Christine Moffatt CBE Associate Professor Sarah Goldberg Professor Bridget Johnston
Nama Institusi *Institution*	:	The University of Nottingham United Kingdom

proposal tersebut dapat disetujui pelaksanaannya.
hereby declare that the proposal is approved.

Ditetapkan di : Bandung
Issued in
Tanggal : 04 – 10 – 2017
Date

Ketua,
Chairman,

Prof. Dr. Firman F. Wirakusumah, dr., SpOG-K
NIP. 19480115 197302 1 001

Keterangan/*notes*:
Persetujuan etik ini berlaku selama satu tahun sejak tanggal ditetapkan.
This ethical clearance is effective for one year from the due date.
Pada akhir penelitian, laporan pelaksanaan penelitian harus diserahkan ke Komisi Etik Penelitian Kesehatan.
In the end of the research, progress and final summary report should be submitted to the Health Research Ethics Committee.
Jika ada perubahan atau penyimpangan protokol dan/atau perpanjangan penelitian, harus mengajukan kembali permohonan kajian etik penelitian.
If there be any protocol modification or deviation and/or extension of the study, the Principal Investigator is required to resubmit the protocol for approval.
Jika ada kejadian serius yang tidak diinginkan (KTD) harus segera dilaporkan ke Komisi Etik Penelitian Kesehatan.
If there are Serious Adverse Events (SAE) should be immediately reported to the Health Research Ethics Committee

Appendix J: Sample of invitation letter of participants

KEMENTERIAN RISET, TEKNOLOGI, DAN PERGURUAN TINGGI
UNIVERSITAS PADJADJARAN
FAKULTAS KEPERAWATAN
JL. Raya Bandung – Sumedang Km 21 Jatinangor 45363, Telp. /Fax 022-7795596
Email: keperawatan@unpad.ac.id

Nomor : 3259/UN6.L/TU/2017 — 11 Oktober 2017
Lampiran : 1 (satu) berkas
Perihal : ***Undangan***

Yth. Dekan FKIK Universitas Muhammadiyah
Yogyakarta

Dengan hormat,

Sehubungan dengan kepentingan riset tentang pengembangan kurikulum untuk mahasiswa jenjang S1 Keperawatan di lingkungan FKep Unpad, maka dengan ini kami mengajukan permohonan agar dapat memberikan ijin kepada salah satu staf dari institusi Ibu/Bapak a.n **Erna Rochmawati, S.Kp., MNSc., M.Med., PhD** untuk menghadiri kegiatan sebagai berikut:

Hari/Tanggal : Senin, 30 Oktober 2017
Pukul : 10.00 WIB s.d. selesai
Tempat : Gedung Rumah Sakit Pendidikan Universitas Padjadjaran
Jl. Prof dr. Ecykman no. 38 Bandung
Kegiatan : Diskusi Kelompok Terarah (*Focus Group Discussion*)
Topik : Pengembangan kurikulum tentang perawatan menjelang kematian, paska kematian dan berduka (*care of the dying, dead and bereaved*)

Sebagai informasi, kegiatan riset ini telah mendapatkan persetujuan etik dari University of Nottingham, United Kingdom (no. reg OVSa020816) dan Komite Etik Penelitian Kesehatan FK Unpad (no.reg 0616090991). Sebagai bahan pertimbangan, kami lampirkan dokumen pendukung yang diperlukan.

Mengingat pentingnya kehadiran Bapak/Ibu dalam kegiatan ini, maka kami mengharapkan konfirmasi tentang kesediaannya dengan cara mengisi dokumen terlampir dan kemudian mengirimkannya melalui email: keperawatan@unpad.ac.id cc Hana.Agustina@nottingham.ac.uk atau fax (022-7796647) atau WhatsApp (+6281214148757) **selambat-lambatnya pada tanggal 23 Oktober 2017**. Jika Ibu/Bapak memerlukan klarifikasi tentang kegiatan ini, maka disilakan untuk menghubungi *contact person* yang tercantum pada dokumen yang terlampir.

Demikian kami sampaikan, atas perhatian dan kesediaannya kami ucapkan terima kasih.

Mengetahui,
Dekan,

Kusman Ibrahim, S.Kp, MNS, Ph.D
NIP 19710917 199903 1 002

Ketua Peneliti,

Hana Rizmadewi Agustina, S.Kp., MN
NIP 19770806 200112 2 001

Tembusan:
1. Wakil Dekan I FKep Unpad
2. Wakil Dekan II FKep Unpad
3. Yang bersangkutan

Appendix K: Summary of included studies based on JBI critical appraisal tools

No	Author	Study design	Score based on JBI appraisal												
			1	2	3	4	5	6	7	8	9	10	11	12	13
1	Mallory (2003)	Quasi-experimental	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
2	Johnston et al. (2006)	Phenonemology	Y	Y	Y	Y	Y	Y	Y	Y	Y	NA	NA	NA	NA
3	Arbour et al. (2014)	Descriptive phenomenolgy	Y	Y	Y	Y	Y	Y	Y	Y	Y	NA	NA	NA	NA
4	Costello (2006)	Ethnography	Y	Y	Y	Y	Y	Y	Y	Y	Y	NA	NA	NA	NA
5	Engler et al. (2004)	Cross-sectional	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
6	Cook et al. (2012)	Qualitative descriptive	Y	Y	Y	Y	Y	Y	Y	Y	Y	NA	NA	NA	NA
7	Kent et al. (2015)	Descriptive quantitative	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
8	Reinke et al. (2010)	Descriptive exploratory	Y	Y	Y	Y	Y	Y	Y	Y	Y	NA	NA	NA	NA
9	Gerow et al. (2010)	Phenomenology	Y	Y	Y	Y	Y	Y	Y	Y	Y	NA	NA	NA	NA
10	Zheng et (2014)	Qualitative descriptive	Y	Y	Y	Y	Y	Y	Y	Y	Y	NA	NA	NA	NA
11	Bloomer et al. (2013)	Descriptive exploratory	Y	Y	Y	Y	Y	Y	Y	Y	Y	NA	NA	NA	NA
12	Chan et al. (2009)	Cross-sectional	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
13	Allchin (2006)	Hermeneutic phenomenology	Y	Y	Y	Y	Y	Y	Y	Y	Y	NA	NA	NA	NA
14	Mallory (2003)	Quasi-experimental	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
15	Mok et al. (2002)	Qualititave	Y	Y	Y	Y	Y	Y	Y	Y	Y	NA	NA	NA	NA
16	Mutto et al. (2010)	Descriptive survey	Y	Y	Y	Y	Y	Y	N	Y	N	Y	Y	Y	Y
17	Kent et al. (2012)	Sequential mixed methods	Y	Y	Y	Y	Y	Y	N	Y	N	Y	Y	Y	Y
18	Adesina et al. (2014)	Mixed methods	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
19	Watts (2014)	Descriptive qualitative exploratory	Y	Y	Y	Y	Y	Y	Y	Y	Y	NA	NA	NA	NA
20	Edo-Gual et al. (2014)	Interpretive phenomenology	Y	Y	Y	Y	Y	Y	N	Y	Y	NA	NA	NA	NA
21	Ek et al. (2013)	Descriptive phenomenology	Y	Y	Y	Y	Y	Y	Y	Y	Y	NA	NA	NA	NA
22	Just et al. (2010)	Mixed methods	Y	Y	Y	Y	Y	Y	Y	Y	Y	NA	NA	NA	NA
23	Wallace et al. (2011)	Quasi-experimental	N	Y	Y	Y	Y	Y	Y	Y	Y	NA	NA	NA	NA
24	Gallagher et al. (2014)	Mixed methods	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
25	Bailey et al. (2014)	Descriptive Phenomenology	Y	Y	Y	Y	Y	Y	Y	Y	Y	NA	NA	NA	NA
26	Parry (2011)	Phenomenology	Y	Y	Y	Y	Y	Y	Y	Y	Y	NA	NA	NA	NA
27	Bloomfield et al. (2015)	Mixed methods	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
28	Ellman et al. (2012)	Mixed methods	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
29	Hold et al. (2015)	Qualitative	Y	Y	Y	Y	Y	Y	Y	Y	Y	NA	NA	NA	NA
30	Shih et al. (2006)	Qualitative exploratory	Y	Y	Y	Y	Y	Y	Y	Y	Y	NA	NA	NA	NA
31	Chow et al.(2013)	Descriptive correlation	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
32	Shadu et al. (2010)	Randomised study	Y	Y	Y	Y	Y	N	Y	Y	Y	N	Y	Y	Y

33	Van der Wrath et al. (2015)	Descriptive qualitative	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
34	Nwozchi et al. (2015)	Hermeneutic phenomenology	Y	Y	Y	Y	Y	Y	Y	Y	Y	NA	NA	NA	NA
35	Von Rooyen et al. (2005)	Descriptive phenomenology	Y	Y	Y	Y	Y	Y	Y	Y	Y	NA	NA	NA	NA
36	Iranmanesh et al.(2010)	Descriptive comparative	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
37	Msiska et al. (2015)	Phenomenology	Y	Y	Y	Y	Y	Y	Y	Y	Y	NA	NA	NA	NA
38	Park et al. (2014)	Phenomenology	Y	Y	Y	Y	Y	Y	Y	Y	Y	NA	NA	NA	NA
39	Brajtman et al. (2009)	Descriptive exploratory	Y	Y	Y	Y	Y	Y	Y	Y	Y	NA	NA	NA	NA
40	Jawahar et al. (2013)	Descriptive exploratory	Y	Y	Y	Y	Y	N	Y	Y	Y	Y	Y	Y	Y
41	Todaro-Francheschi et al. (2014)	Descriptive exploratory	Y	Y	Y	Y	Y	Y	Y	Y	Y	NA	NA	NA	NA
42	Jeffers (2014)	Phenomenology	Y	Y	Y	Y	Y	Y	Y	Y	Y	NA	NA	NA	NA
43	Lippe et al. (2015)	Descriptive quantitative	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
44	White et al. (2011)	Cross-sectional	Y	Y	Y	Y	Y	Y	Y	Y	Y	NA	NA	NA	NA
45	Jo et al. (2015)	Quasi-experimental	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
46	Wilson et al. (2011)	Descriptive comparative	Y	Y	Y	Y	Y	N	Y	N	Y	Y	Y	Y	Y
47	Jayasekara (2013)	Qualitative exploratory	Y	N	Y	Y	Y	Y	N	Y	Y	NA	NA	NA	NA
48	Modeste (2015)	Mixed methods	Y	N	Y	Y	Y	Y	N	Y	Y	Y	Y	Y	Y
49	Kavanaugh et al. (2009)	Case study	Y	Y	Y	Y	Y	Y	Y	N	Y	NA	NA	NA	NA
50	Thacker (2008)	Comparative descriptive	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
51	Kongsuwan et al. (2009)	Phenomenology	Y	Y	Y	Y	Y	Y	Y	Y	Y	NA	NA	NA	NA

Note: *JBI QARI (qualitative study) and JBI MasTARI (quantitative and mixed methods study)

No	Author	Design	Score based on JBI appraisal												
			1	2	3	4	5	6	7	8	9	10	11	12	13
1	NICE (2011; 2015)	Practice guidelines	Y	Y	Y	Y	Y	Y	Y	NA	NA	NA	NA	NA	NA
2	EAPC (2010)	Policy papers	Y	Y	Y	Y	Y	Y	Y	NA	NA	NA	NA	NA	NA
3	Ramjan et al. (2010)	Case report	Y	Y	Y	Y	Y	Y	N	NA	NA	NA	NA	NA	NA
4	Smith-Stoner (2011)	Case report	Y	Y	Y	Y	Y	Y	N	NA	NA	NA	NA	NA	NA
5	Gamondi et al. (2013)	Policy paper	Y	Y	Y	Y	Y	Y	Y	NA	NA	NA	NA	NA	NA
6	Hegarty et al. (2010)	Scoping study	Y	Y	Y	Y	Y	Y	Y	NA	NA	NA	NA	NA	NA
7	Murray et al. (2015)	Book chapter	Y	Y	Y	Y	Y	Y	Y	NA	NA	NA	NA	NA	NA
8	APCA (2015)	Policy paper	Y	Y	Y	Y	Y	Y	Y	NA	NA	NA	NA	NA	NA
9	Brien et al. (2008)	Case report	Y	Y	Y	Y	Y	Y	Y	NA	NA	NA	NA	NA	NA
10	Loos et al. (2014)	Case report	Y	Y	Y	Y	N	Y	Y	NA	NA	NA	NA	NA	NA
11	Condon et al. (2014)	Reflective writing	Y	Y	Y	Y	Y	Y	Y	NA	NA	NA	NA	NA	NA
12	Taylor et al. (2012)	Project report	Y	Y	Y	Y	Y	Y	Y	NA	NA	NA	NA	NA	NA
13	Ferrell et al. (2015)	Original article	Y	Y	Y	Y	Y	Y	Y	NA	NA	NA	NA	NA	NA
14	Connolly et al. (2014)	Project report	Y	Y	Y	Y	N	Y	Y	NA	NA	NA	NA	NA	NA
15	Poultney et al. (2015)	Case report	Y	Y	Y	Y	Y	Y	N	NA	NA	NA	NA	NA	NA
16	Bassah et al. (2014)	Systematic review	Y	Y	Y	Y	Y	Y	N	NA	NA	NA	NA	NA	NA
17	Cavaye et al. (2014)	Integrative review	Y	Y	Y	Y	Y	Y	N	NA	NA	NA	NA	NA	NA
18	Fonseca et al. (2012)	Systematic review	Y	Y	Y	Y	Y	Y	N	NA	NA	NA	NA	NA	NA
19	Stephen et al (2012)	Project report	Y	Y	Y	Y	Y	Y	N	NA	NA	NA	NA	NA	NA

Note: Appraisal of included studies based on JBI NOTARI

Appendix M: COREQ checklist

No.	Question	Answer	Location ithesis
1	Which author/s conducted the interview or focus group?	The researcher (HRA)	Methodology chapter, research method page 77 section 3.3.4 para 3, and page 77 section 3.3.4
2	What were the researcher's credentials? *E.g. PhD, MD*	PhD student, nurse graduate	Page 25 introduction chapter, section 1.7 para 4
3	What was their occupation at the time of the study?	PhD student	Idem
4	Was the researcher male or female?	Female	Idem
5	What experience or training did the researcher have?	PhD training	Page 187 Reflexivity chapter section 8.2 para 2
6	Was a relationship established prior to study commencement?	Some participants were previous students and working colleagues of the researcher	Page 187 Reflexivity chapter section 8.2 para 3
7	What did the participants know about the researcher? e*.g. personal goals, reasons for doing the research*	The fact that this study was part of a PhD has explicitly explained to participants. The researcher has created flyers, participant information sheet, and conducted several presentations to disseminate the study. Such efforts helped the researcher to inform about her role as PhD student and her contact details.	Page 85 methodology chapter section 3.6 Ethical considerations table 8
8	What characteristics were reported about the interviewer/facilitator? e.g. Bias, assumptions, reasons and interests in the research topic	The researcher used to deliver teaching sessions with students.	Page 78 methodology chapter section 3.3.5 para 2
9	What methodological orientation was stated to underpin the study? e.g. grounded theory, discourse analysis, ethnography, phenomenology, content analysis	Descriptive and interpretive thematic analysis and constant comparison	Page 71 section 3.2 para 2 and page 74 section 3.2.2
10	How were participants selected? *e.g. purposive, convenience, consecutive, snowball*	Non-probability and purposive sampling for semi-structure interview and focus group	Page 74 methodology chapter section 3.3.5 para 1
11	How were participants approached? e*.g. face-to-face, telephone, mail, email*	Interview student participants and faculty staff approached by academic teaching and clinical learning coordinator. Ward staff approached by the researcher and a clinical instructor manager.	Page 77 methodology chapter section 3.3.5 para 2 Page 77 methodology chapter section 3.3.5 para 2
12	How many participants were in the study?	13 students, 12 faculty staff, and 5 clinical instructors	Page 77 methodology chapter section 3.3.5 para 2
13	How many people refused to participate or dropped out? Reasons?	No	N/A

14	Where was the data collected? e.*g. home, clinic, workplace*	The interviews conducted in workplace (e.q private room) and public area (e.q. café)	Page 75 methodology chapter section 3.3.2 para 6
15	Was anyone else present besides the participants and researchers?	No	N/A
16	What are the important characteristics of the sample? e.g. demographic data, date	Students with dying and death experiences during clinical learning. Nurse educators with classroom teaching and/or clinical supervision experiences.	Page 78 methodology chapter section 3.3.2 para 1 table 6
17	Were questions, prompts, guides provided by the authors? Was it pilot tested?	Topic guides were used and tested with colleagues from same department with the researcher prior to use.	Page 75 methodology chapter section 3.3.2 para 3
18	Were repeat interviews carried out? If yes, how many?	No	Page 76 methodology chapter section 3.3.2 para 1
19	Did the research use audio or visual recording to collect the data?	Digital audio recordings of interviews and video recordings of focus group discussion.	Page 75 methodology chapter section 3.3.2 para 2
20	Were field notes made during and/or after the interview or focus group?	Field notes were made after the interview	Page 75 methodology chapter section 3.3.2 para 3
21	What was the duration of the interviews or focus group?	30 to 90 minutes	Page 75 methodology chapter section 3.3.2 para 3
22	Was data saturation discussed?	Data saturation was believed to occur around two thirds into data collection.	Page 75 methodology chapter section 3.3.2 para 3
23	Were transcripts returned to participants for comment and/or correction?	Yes	Page 86 methodology chapter section 3.6.4 para 2
24	How many data coders coded the data?	One	Page 81 methodology chapter section 3.4.2 para 2
25	Did authors provide a description of the coding tree?	Yes	Page 81 methodology chapter section 3.4.2 table 7
26	Were themes identified in advance or derived from the data?	Derived from the data	Page 81 methodology chapter section 3.4.2 para 3
27	What software, if applicable, was used to manage the data?	NVIVO 11	Page 80 methodology chapter section 3.4.1 para 4
28	Did participants provide feedback on the findings?	Yes	Page 86 methodology chapter section 3.6.4 para 2
29	Were participant quotations presented to illustrate the themes / findings? Was each quotation identified? e.*g. participant number*	Participant's quotations presented to illustrate themes and findings.	Findings section
30	Was there consistency between the data presented and the findings?	Yes	Findings section
31	Were major themes clearly presented in the findings?	Yes	Findings section
32	Is there a description of diverse cases or discussion of minor themes?	Yes	Findings section