Learning, development, and support needs of community palliative care clinical nurse specialists

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Background

The PC-CNS role

Skilbeck et al (2002) found that the main reasons for referral to a PC-CNS were for pain and other symptom management and for emotional support for the patient and/or carer. This may be a reflection of how referrers perceive the role and how these PC-CNSs organise and deliver services. Studies have shown that PC-CNSs view emotional care and support for patients and their loved ones as ‘pivotal’ to their ‘sense of professional identity’ and as contributing to their sense of job satisfaction (Skilbeck and Seymour, 2002: 580). By contrast, managerial expectations were of a more strategic approach to the role.

Emphasis has been placed on the need to further develop the education and research components of the role (Seymour et al, 2002). Participants in the Seymour et al (2002) study indicated a desire to further develop the non-clinical aspects of their role, in particular the education remit. They reported that they rarely if ever...
Box 1. Main roles and responsibilities of the palliative care clinical nurse specialist*

Clinical practice
- Specialist nursing assessment of the needs of patients, families, and other carers with complex needs
- Plan care for patients and families in consultation with them and other health professionals involved in their care
- Provide expert knowledge and advice to health professionals to enable them to treat patients with complex symptoms effectively

Education and professional development
- Use opportunities to informally educate and teach patients, families, and professional carers to increase awareness and skills in palliative care
- Identify health professionals’ education needs and work with existing statutory and voluntary organisations to plan and deliver specialist education and training
- Undertake continuous professional development activities

Research and development
- Develop and contribute to specialist protocols, policies, and procedures relevant to palliative care
- Participate in research activities
- Use and promote reflective practice
- Undertake clinical audit and promote findings and implement recommended changes in the audit cycle

Leadership and management
- Caseload management
- Effective team working

*United Kingdom Central Council (2001)

fulfilled all components. This led to a sense of work overload and conflicting expectations between the need to maintain clinical credibility with the public and other professionals through direct patient contact and the need to meet organisational expectations. Furthermore, many participants felt educationally ill prepared and lacking the resources to deliver the teaching component of the role. Studies have also indicated that there are inconsistent professional development opportunities across teams (Seymour et al, 2002; Husband and Kennedy, 2006; Newbury et al, 2008).

Stress and staff support needs
Caring for patients at the end of life is reported to be rewarding but emotionally stressful (Gambles et al, 2003; Tunnah et al, 2012). However, professionals working in palliative care settings exhibit less stress than those caring for patients who are dying in other settings (Vachon, 1995). Although the ethos and philosophy of hospice care may contribute to hospice environments being less stressful areas of work (Vachon, 2000), work stressors identified by community-based PC-CNSs include workload pressures (including staff shortages), lack of management appreciation of effort, and insecurity arising from organisational changes (Newton and Waters, 2001). These findings were substantiated by Hawkins et al (2007), who reported feelings of inadequate preparation for coping with the emotional needs of patients and families as a significant source of stress. Tunnah et al (2012) reported that conflict with professionals outside the team was also a major stressor, and that job satisfaction was an important determinant of overall levels of stress.

Learning and development support needs
Booth et al (2003) surveyed all Macmillan nurses and other Macmillan professionals in England, Scotland, and Wales, with a response rate of 76%, and identified significant practice development needs, with a particular need for organisational support. They reported that a lack of time and a heavy workload were major barriers to practice development. Booth et al (2003) held focus groups to explore their findings in more detail. They reported participants as saying that poorly defined role responsibilities led to unrealistic expectations from colleagues and that participants felt unsupported and unprepared for their role. Improvements in practice were found to be more likely when both personal and organisational factors promoted change. Although formal qualifications were considered important, Bamford and Gibson (2000) found that clinical experience was also highly valued.

Research is a core component of the PC-CNS role, but no literature was found in relation to research development needs.

Summary
The literature identifies some of the stressors of the PC-CNS role, including learning and development support needs. However, there is a clear need to further elicit both organisational and individual needs and identify strategies to address them.

Aim
This paper reports a study undertaken to investigate what PC-CNSs in one independent hospice in Northern Ireland need in terms of learning, development, and support to enable them to fulfil all of the components of their role.

Method
A qualitative enquiry with a descriptive exploratory approach was used to address the study aim, as transferable insights can be gained from the analysis of recounted experiences (Todres and Holloway, 2006).
Setting
The hospice provides specialist inpatient, day, and community services. It currently employs nine adult community specialist palliative care teams. These work across three of the four health trusts in Northern Ireland, providing services to approximately 1.5 million people (Northern Ireland Statistics and Research Agency, 2014). The nine PC-CNS teams are supported by consultants in palliative medicine.

Sample
A purposive sample (Streubert and Carpenter, 1999) was taken from the hospice’s population of 33 community PC-CNSs. Those on maternity leave, retiring within the next 6 months, or working 15 hours per week or less were excluded. To avoid selection bias, there were no other exclusions.

Data collection
The first author works as a PC-CNS in the host organisation. She attended community team meetings to inform all staff about the study, answer any questions, and distribute information packs. Study packs contained a cover letter, reply slip, consent form, participant information sheet, and stamped addressed envelope. Recruitment was confirmed by participants returning the reply slip and consent form to the first author, indicating that they had experience working as community PC-CNSs and were willing to take part in an audio-recorded one-to-one face-to-face interview. Semi-structured interviews were conducted using an interview schedule (Box 2) at a time and place agreed with the participants. The schedule allowed flexibility to follow up on issues raised during the interviews that had not been anticipated, thereby being responsive to the views of participants (Tod, 2006). It was developed following an initial review of the literature and was informed by a previous study, with permission (Bamford and Gibson, 2000). To identify ambiguities or other deficiencies in the design of a study tool, Lacey (2006) recommended pilot testing the interview schedule before embarking on the main study. This was done with one participant: minimal changes were made to the interview schedule and the pilot data was included.

Data analysis
The interviews were audio-recorded and transcribed verbatim. The data was thematically analysed using the six-step pragmatic approach advocated by Newell and Burnard (2006). The interview recordings and transcripts were read and listened to and recheck their accuracy and enable the researcher (EW) to become immersed in the data. This allowed the researcher to identify initial open codes that were then condensed into categories. To address rigour in the analysis, these were checked by WGK and DM and themes identified for discussion and agreement. Similarly, to minimise reporting bias, the authors fully collaborated on the final manuscript.

Ethical considerations
No serious ethical issues were identified. Written information regarding the study was given to each participant. Consent was obtained from participants prior to the interviews and confirmed orally at each interview. To ensure confidentiality, a unique identification code known only to the researchers was allocated to each participant. Data was stored on a password-protected computer and written information was kept in a locked cabinet accessible only to the researcher. In accordance with the Data Protection Act (1998) and University of Ulster policy, the data will be destroyed in 10 years’ time. Approval to undertake the study was obtained through arrangements for Research Governance at the University of Ulster. Permission to recruit staff for participation was obtained from hospice management. All local research governance procedures were adhered to.

Box 2. Interview schedule

1. Tell me about the various aspects of your role as a hospice nurse specialist or hospice community nurse
   (Probes: To what extent do you fulfil each component of the role? What are the challenges to fulfilling the components of your role at present?)

2. What support is currently available to assist you in fulfilling the various aspects of your specialist role?
   (Probes: Support in relation to: clinical, educational, research, management, and self-care issues. What specific support is available around working in palliative care or intensely with death and dying? What support, if any, have you used?)

3. Tell me about any aspects of your role, if any, that you feel you would need to focus on?
   (Probes: Why do you feel you need to develop these aspects of the role? Can you be more specific? If no focus is needed, move to question 4)

4. What education or training do you think is required to assist you to address the various aspects of the role?
   (Probes: Tell me about how your work in clinical, education, research, and management areas might be enhanced? In what format should the education or training be delivered to best meet your learning needs?)

5. In meeting your learning and development needs, what helps and what hinders?
   (Probes: What helps? What hinders? What would help?)

6. Is there anything else that you would like to say that we haven’t covered?
Findings

Of the 33 nurses invited to participate, nine band-7 and eight band-6 PC-CNSs agreed to take part. Demographic details are shown in Table 1. Participants identified significant learning, development, and support needs pertaining to all four aspects of their role. Three main themes emerged from the analysis: influence of organisational culture, influence of the individual, and learning and development solutions. These themes were underpinned by a number of categories of meaning (Table 2).

Influence of organisational culture

Various aspects of organisational culture influenced both the learning, development, and support needs of the participants and how the components of the role were fulfilled.

Informal peer support within the teams was a predominant organisational support mechanism.

Formal organisational support, including induction, mentoring, and clinical supervision, was also highly valued. However, some participants indicated that there was limited formal support available for working intensely with death and dying. One participant highlighted ambiguity around what formal support was available:

‘People use their colleagues and that would be the major form of support … I did use the counsellor that is attached to the hospice once ... and found it beneficial ... but I was informed of that indirectly [by chance] not formally.’
(Hospice nurse specialist (HNS) 02)

Working relationships were a critical part of available support. Stability in the team helped to create better teamwork. Although working with GPs and other members of the primary health care team could be challenging, the participants identified that having increased knowledge and skills enhanced their confidence and improved their working relationships with GPs. This was associated with professional credibility, which was enhanced where the level of consultant support was deemed high.

‘From a clinical support side of things, probably my main support would be the consultant ... and sometimes it helps with the GPs if they know you’ve discussed it with the palliative care consultant. Maybe a drug that they’re not confident in increasing...’
(HNS 05)

‘If you’re working well in a team and getting supported in a team and you’ve a good working relationship with your consultant and your clinical meetings are good, that’s your support, that’s what helps your learning and development. Because you are supported in your role, you will learn ... it’s a safe environment.’
(Hospice community nurse (HCN) 14)

Management support was essential to staff feeling valued and developing to their full potential:

‘[The working group] is ... quite good because the dates are set in advance and [the manager] would be very good in making sure that you attend those and that you sort that out within the team that you can be released …’
(HCN 15)

‘I think you can learn as part of the job if you are allowed to. You could be given the opportunity to develop your leadership and management skills in various aspects of the job and get feedback on how you do that ... if one of us

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Table 1. Participant demographic information
could go to a strategy meeting that higher levels of management go to at the minute and feed back on that...’ (HNS 01)

Management of the various components of the role was challenging. Although participants recognised their responsibility to fulfil all components of the role, the clinical component was always given priority. The extent to which they fulfilled other components depended both on their membership of various working groups and their level of experience. The clinical, leadership/management, and education components were considered by some to be interconnected, with the informal education of the patient, family, and multidisciplinary team being seen as an essential part of the role. However, fulfilment of the research component of the PC-CNS role was considered to be more challenging.

‘... I would be fulfilling the education role. As regards the leadership part, yes I do feel that I am able to meet the leadership role...’ (HNS 03)

‘... from the research point of view, the other three components of my job, I really don’t have issue with, but the research aspect just kind of sits out because we don’t have the time to do it ...’ (HNS 04)

The role was constantly changing and expanding in response to organisational, regional, and national strategic development. Being responsive to the changing needs of the service was challenging, particularly as the role currently holds limited strategic influence and limited autonomy for decision making regarding the service. Greater autonomy among teams would be welcomed.

‘... the nature of how community teams operate [is that] we have this flat structure where you don’t have this leadership within the team, where everyone is a leader basically so that doesn’t allow you to develop that component of the role.’ (HNS 09)

Resource management affected the time available for the effective fulfilment of the role and the use of learning and development opportunities.

‘I feel because we are so clinically focused at the minute [that] to try and fit in the other components of the role is a real challenge and as I chatted about doing that literature search, I ended up doing a lot of that in my own time ...’ (HNS 07)

‘... time out from the team to attend sessions ... being fair and everybody getting their chance and maybe if there was some kind of rotating constant teaching programme that we could dip in and out of ...’ (HCN 15)

**Influence of the individual**

This theme related to how the learning, development, and support needs of individuals were shaped by different personalities.

The PC-CNS role has an intense emotional impact. However, there appeared to be limited emphasis placed on self-care.

‘... personally I don’t feel that there is a lot of support, it’s something that you need to self-manage and it can be difficult because it is busy and I personally don’t feel that enough recognition is given for self-preservation in this job because it is very stressful ...’ (HNS 02)

As lone workers, PC-CNSs reported a great sense of responsibility for patient wellbeing while also feeling very isolated at times. The stressful nature of the role and its competing demands made formal support mechanisms essential but difficult to implement effectively:

‘... years ago we used to have half-day study days, half-day support days once a month ... it was very beneficial ... but I think that it is something that needs to come back because at the moment, we really don’t have any support ... we will try and have maybe a coffee out maybe once a month but actually putting it into practice ...’ (HNS 03)
Self-awareness was reported as being essential to recognising and managing stress appropriately. Coping strategies developed with experience and were associated with individual personalities.

‘... support in our role ... is probably lacking ... we can go and knock on someone’s door but the longer I’ve been in palliative care and working in a specialist role I think you build up a resilience to the role because I think if you didn’t do that you wouldn’t be able to cope ...’ (HNS 07)

‘... first and foremost I think you need to identify yourself that there is a problem and then you need to find which channel you’re going to take it through, whether it is team level through supervision, whether you’re going to go to your line manager, take it through occupational health or whatever ...’ (HNS 04)

Identified personal characteristics either challenged or enabled individuals to prioritise and value their own continuous learning and development needs:

‘... you need to feel motivated so you need to get encouragement and feel you’re doing a good job ... If you enjoy it you want to learn more ... access to study days, encouragement to go to them ... time allocated to go to them ...’ (HNS 02)

Up-to-date evidence-based specialist knowledge and skills were deemed essential to working collaboratively, confidently, and competently:

‘... we all need to get updated so I really think it will enhance my role because it will give me increased competence in ... doing these assessments and it will also help me whenever I’m going to speak to GPs, that I am using the right terminology ... ’ (HNS 03)

Formal education helped to consolidate and validate existing knowledge, skills, and experience and build confidence to fulfil all aspects of the role:

‘... I know ... there are learning needs there for me as in having a qualification in palliative care ... to ... have the backup of actual study ... I very much need to do this course ... just having the reassurance that I am actually working at what I am doing.’ (HCN 14) (New in post)

Learning and development solutions

The PC-CNSs made suggestions for how learning and development may best be achieved.

Because individuals learn in different ways, creative organisational solutions to identifying and facilitating individual learning and development needs may be delivered using a partnership approach while sharing the knowledge and expertise available in the organisation and keeping costs down:

‘...I think [the organisation] needs to look at ways to support and facilitate us. There is so much expertise ... within the consultants, within nursing staff that have moved on to doctorate level ... so we should really be trying to gain our knowledge and skills from what is available in-house ...’ (HNS 07)

‘... often the courses are expensive and in some ways I feel like we shouldn’t have to be paying for them especially because they are in-house ...’ (HCN 15)

The majority of personal learning was said to be experiential learning in practice settings. Having the opportunity to put theory into practice was deemed very important for continuous self-development, as was the opportunity to learn from others through role modelling. Experience in the role also enhanced confidence and the ability to develop non-clinical components.

‘... formal teaching certainly, there is always something to gain from that but also informal in shadowing and in watching and observing other people and that is difficult when you are a lone worker ...’ (HCN 12)

‘... it might be good to rotate staff within [working] groups on an annual or 2-year basis to give you a chance to get involved and maybe that would help us fulfil different aspects of your role ... ’ (HCN 15)

Summary

The participants identified the importance of both the organisation and the individual and offered potential solutions for how the learning and development needs of the PC-CNS may best be met.

Discussion

The findings indicate that the organisational culture and individuals influence the learning, development, and support that community PC-CNSs need to fulfil all aspects of their role.
Although these are not new findings, the categories within the themes do offer new information.

Organisational culture has a significant effect on how the PC-CNS role is interpreted and practised. The findings highlighted the importance of management valuing staff and providing opportunities for staff development. This reflects previous findings from Newton and Waters (2001). Participation in education activities, and overall self-development, have been linked to organisational behaviour, with managerial support enabling staff to realise their full potential (Booth et al, 2003).

The PC-CNSs said they heavily relied on informal support from other team members. Arber (2007) found that team meetings can be a valuable source of formal support and a safe environment in which to discuss practice issues. The current study found that each team functioned differently, with the perceived learning environment and relationships between team members being strongly influenced by the stability of the team and the consistency of the consultant support available. Their relationships with the consultants influenced how the nurses interacted with colleagues in the primary health-care team. Those who had a consistently supportive relationship with medical colleagues identified enhanced confidence in their knowledge and skills and better working relationships with GPs. Similarly, Booth et al (2003) found that the support of senior colleagues significantly influenced how specialists undertake their role. Erosion of normal organisational support mechanisms, including clinical supervision, team support, and support from senior medical staff, has been found to have a negative effect on individuals’ ability to cope with their roles. Multiple organisational changes have also been reported to be significant work stressors for community-based PC-CNSs (Newton and Waters, 2001).

The PC-CNS role has four distinct components. Previous research showed that although PC-CNSs indicate a desire to further develop the non-clinical aspects of their role, in particular the education remit, they rarely fulfil all components of their role (Seymour et al, 2002; Husband and Kennedy, 2006; Newbury et al, 2008). Those who do so often fulfil their overall workload commitments in their own time (Husband and Kennedy, 2006; Newbury et al, 2008), as confirmed in the current study. Astin et al (2008) found that non-clinical aspects of the role cannot be developed without a reduction in clinical workload.

Participants recognised the importance of all four components of the role, although the majority were not involved in research to inform practice. Nevertheless, the more experienced PC-CNSs were very aware of the need to be actively involved in research. Some participants indicated that they would welcome the opportunity to participate in research in their individual teams along with a more strategic role in the delivery of the service. All participants highlighted that there was a flat management structure in their teams, and some identified that this inhibited the development of their leadership and management skills, suggesting that a rotational team leader role may assist with this. Previous research indicates that team leaders spend more time on policy development and less time on direct patient involvement (Skilbeck and Seymour, 2002). The impact of such a change would need to be considered carefully given the limits in resources. Development of non-clinical components of the role may be better facilitated through regular planned rotation of staff onto project working groups.

Limited resources, including inadequate staffing levels, lack of time, and limited financial support, have previously been identified as a barrier to development in the PC-CNS role (Bamford and Gibson, 2000; Newton and Waters, 2001; Astin et al, 2008). Although these barriers were also identified here, participants appreciated the fair distribution of limited resources by management in terms of access to continuing formal education and suggested that greater use of expertise within the organisation may assist with learning and development needs while managing limited resources.

The complexity of the PC-CNS role can lead to self-conflict when reconciling personal and organisational expectations of the role with the skills of the individual (Husband and Kennedy, 2006). The current study found that competing demands of the role make formal support mechanisms essential but difficult to implement. Although participants placed limited emphasis on self-care, there was clear awareness of individual responsibility for recognising and managing one’s own stress. Although PC-CNSs work as part of a team, they predominantly work alone. Feelings of isolation have previously been reported in relation to a lack of understanding of the role and the expectations of others (Bamford and Gibson, 2000). This causes practitioners to experience ‘professional loneliness’ (Booth et al, 2003). Newton and Waters (2001) also described feelings of isolation associated with the demands of acting as key worker for patients and families with complex needs. This concurs with findings from the current study, in
which participants felt a great sense of responsibility for patient wellbeing.

Findings from this study indicate that PC-CNSs have significant learning, development, and support needs, irrespective of their experience in the role. Although experienced staff expressed a desire to develop other components of their role, they also identified the need for continuous development of the clinical component, highlighting the requirement for ongoing practical and clinically focused updates for all staff, irrespective of experience. The importance of relevant, flexible education and the need to be perceived as credible, competent practitioners have previously been identified (Gibson and Bamford, 2001).

Credibility and competence were predominantly associated with being seen by other health professionals to have up-to-date evidence-based clinical knowledge and skills, as evidenced by the attainment of relevant higher qualifications (Astin et al, 2008).

**Recommendations**

The literature indicates that improvements in practice are more likely when both personal and organisational factors are considered in order to facilitate and adequately resource a positive culture for change (Booth et al, 2003). The challenge is to develop creative solutions that facilitate individual learning and development within the constraints of limited resources and overall expectations of the role. This may be best achieved through a partnership approach in which knowledge and expertise available in the organisation is valued, used, and shared across directorates. Ongoing programmes of knowledge and skills development must be relevant and responsive to the changing needs of practice. As individuals learn in different ways, various formats may need to be considered, including face-to-face, self-directed, online, and blended approaches.

Experiential learning was highly valued by staff. Although initial learning and development needs of new staff are catered for through the induction programme, the ongoing needs of experienced staff should also be considered and may be supported through rotation onto project working groups or into team leadership. Role modelling through shadowing more experienced staff may also be helpful but would have significant implications for service delivery.

Further consideration is required as to how the research component of the role may be supported. It is likely that this component will depend on close working relationships with local providers of higher education in palliative care. This is currently being explored.

Experiential learning must be balanced with theoretical underpinning if staff are to feel confident in their practice and be considered competent practitioners by generalist colleagues. Although courses leading to accredited qualifications help to validate current knowledge, skills, and experience, non-accredited courses may also be valuable in ensuring self-validation of practical experience. A combination of both approaches may ensure a competent and confident workforce who feel valued and supported.

**Study limitations**

The first author works as a PC-CNS in the host organisation. Although ‘insider knowledge’ informed the overall design of the study and provided ready access to participants, it may also have impeded full disclosure of information by some. For practical, governance, and ethical reasons, it was not possible to consider working in an unknown context.

The study focused on the PC-CNSs’ perceptions of their learning development and support needs. However, it may have been beneficial to interview managers to identify their perceptions of the learning and development needs of staff and the organisational support mechanisms that are available to meet those needs.

**Conclusion**

This study sought to provide insight into the learning, development, and support that community PC-CNSs need to fulfil the four components of their role. Although this was a limited study based in one hospice, it provides further illumination of findings from previous studies and begins to explore means to address learning, development, and support needs.

Participants confirmed the stressful nature of the PC-CNS role and identified that the organisational culture and individuals themselves influence the learning and development support available to fulfil the four components of the role. The value placed on staff and staff development by management was said to have a significant influence on the learning culture. Greater use of the expertise of individuals in the organisation was suggested as a way to meet learning and development needs while managing limited resources. Formal organisational support mechanisms pertaining directly to the specific knowledge, skills, and experience required to fulfil the components of the role were widely used and valued. Working relationships and stability in teams had a significant impact on how sup-
ported individuals felt and must be considered by management when trying to meet the needs of individual staff while balancing the needs of the service.

Declaration of interests
This work had no external sources of funding. The authors have no conflicts of interest to declare.

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