Nursing students' knowledge, attitude, and self-efficacy of palliative care towards end-of-life Nursing in Laos.

A Thesis Submitted to the Department of Cancer Control and Population Health in Partial Fulfillment of the Requirements for the master's degree of Public Health

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ABSTRACT

Nursing students' knowledge, attitude, and self-efficacy of palliative care towards end-of-life Nursing in Laos.

Background:

In a study on the knowledge and attitudes of nursing students toward end-of-life care, it was reported that cultural and religious beliefs, along with the education level of nursing students, palliative care education, and experiences of caring for the dying patients, are various factors that can have a positive or negative effect, there is in 1994, the World Health Organization (WHO) said that palliative care provided to dying patients in the existing knowledge system is the most effective for the quality life of patients.

In this context, palliative care should be provided in order to provide holistic care for patients at the end of life to face the last moments in peace in order to maintain human dignity and high quality of life for the rest of their lives. Nursing students should develop knowledge and attitudes within the curriculum so that they can be integrated into nursing practice as an important human resource for providing quality palliative care as a preliminary stage of the professional workforce.

For this, it can be seen that an independent curriculum is necessary for university education. Therefore, this study intends to identify the relationship

between Lao Nursing University students' knowledge of palliative care, attitudes toward end-of-life nursing, and variables on self-efficacy, and use them as basic data applicable to the Lao University of Nursing undergraduate or diploma course.

Objective:

The purpose of this study was to examine nursing students' knowledge, attitudes, and self-efficacy about palliative care and look at the relationships between these variables in Laos.

Methodology:

This was a descriptive, cross-sectional study, the population and sample size in this study were higher diplomas of a nursing program from six schools of nurses in Laos (N= 269) at the end of the third year were surveyed. The instrument for the measure included the Demographic questionnaire, The Palliative Care Quiz for Nursing (PCQN-L) 20 items, the Death Attitude Profile-Revised (DAP-R-L) 32 items, the Palliative Care Self-Efficacy Scale (12 items), and the Fromelt Attitude towards care of dying (FATCOD-L) 30 items. Data analysis the Stata program (version 15.1) was used for analysis and the statistical analysis method consists of the general characteristics of the subjects are analyzed as real numbers, percentages, mean and standard deviation, total score, average, and standard deviation, and Pearson’s correlation coefficient.

Result: the total of 269 students from six nursing colleges, were gender female: 221(82.2%), Male: 48(17.8%), age under 20 was 67 (24.9%) and over the age of 20 was 202 (75.0%), 254 (94.4%) unmarried, and Buddhism 199(74.0%), the total mean score of PCQN-L was 13.16The category with the percentage of correct responses of accurate answers on Philosophy and principle of palliative care was73.4 %, pain, and symptom management was 61.02 % and psychosocial and spiritual care was (76.82 %). Mean subscales scores remarkable on the 5 subscales with high scores was Fear of Death was 4.23Approach Acceptance was 4.14 and avoidance of death was 4.11Meanwhile, as can be seen in, the percentages of Escape Acceptance 3.95 and Neutral Acceptance 2.95 both had a low score. the students' overall FATCOD-L mean score for attitudes about caring for dying patients was 3.16According to the investigators, the palliative care self-efficacy scale had a mean score of 2.49 the mean score for the subscale "Psychosocial support" was 2.45, while the mean score for the subscale "Symptom management " was 2.54. A Pearson correlation was used to evaluate several statistically significant correlations that emerged from studies of knowledge, death attitudes, attitudes toward caring for the dying, and self-efficacy in the total group noticeable, between fear of death and the FATCOD-L was established moderate positive. further, there was a weak negative association between fear of death and death avoidance besides,

there was a weak negative link between fear of death and escape acceptance Similarly, there was a weak negative correlation between neutral acceptance and escape acceptance neutral acceptance and FATCOD-L, fear of death and self-efficacy escape acceptance and FATCOD-L and escape acceptance and Self-efficacy Furthermore, both the FATCOD-L – (Self-efficacy) and Neutral acceptance – Approach acceptance correlations shown moderate negative correlations.

Conclusion:

The students of Lao Nursing School did not receive compulsory education in palliative care, and only a few subjects related to palliative care for chronic and serious diseases were taught. However, palliative care is crucial. The author suggests applying the results of this study to improve and develop their education field, we intend to teach nursing students who will work directly in the area of nursing how to perform the delicate and difficult process of end-of-life care at nursing schools, which will serve as the basis for future palliative care in Laos.

Keywords: Nursing students, knowledge, attitude to death, self-efficacy, palliative care.

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List of Abbreviations

PCQN Palliative Care Quiz for Nursing

DAP-R-L Death Attitude Profile-Revised Scale

FATCOD-L Frommelt Attitude Toward Care of Dying Scale

N/A Not applicable

NECHR National Ethics Committee for Health Research

Chapter 1

Background and Literature review

1. Introduction

1.1 Palliative care and cancer burden.

In Lao People's Democratic Republic total number of new cancer case is 9,133 The five most common cancers in Laos are (1) liver 1,272 (13.9%), (2) breast cancer 1,080 (11.8%), (3) lung cancer 1,023 (11.2%), colorectum cancer 799 (8.5%), 4) stomach cancer 675 (7.4%) and other cancer 4,304 (47.1%) 3 Currently cancer is on the rise around the world, with estimated number of new cases in 2020 both sex total: 19,292,789. The common cancer is 1) breast cancer 2,261.419, 2) Lung cancer 2,206.771, 3) colorectum cancer 1,931.590, prostate cancer 1,414.259, 5) stomach cancer 1,089.103, 6) liver cancer 905,677, 7) cervix uteri 604,127 and the other cancer 8,879.843(WHO International Agency for Research on Cancer 2020).

1.2 The need for palliative care for nursing students.

In June 2008 Laos had begun establishing a national cancer center at Mittaphab Hospital in Vientiane capital. The first hospital-specific on cancer, however, limited some cancer diagnoses and surgery was not cover all types of cancer (Tl et al. 2011). Management of Nursing Education in Laos, Ministry of Public health has a policy that Requires professional nurses to have knowledge and skills, which

is part of the development and focus on students to have the responsibility, professional ethics that provide service to practice public health professions and take care of public health through (Ministry of Public Health, Lao People's Democratic Republic 2013), which the official study Nursing such as Diploma Program in Nursing (3 years) by Faculty of Nursing, University health science Laos is responsible for producing nurses at the level graduates, while colleges, schools, and training centers play a role in producing diploma-level nurses and Technical nurses, which in 2017 – 2019. Characteristics of Nursing Diploma Programs of Nursing Institutes in Laos, the teaching and learning management is divided into 3 parts: 1) Theoretical part focuses on the knowledge of the content, principles of adult nursing, principles of Geriatric nursing with academic knowledge by using a variety of teaching methods such as descriptive teaching, some part of lesson related to taking care chronic of diseases, critical diseases that intervention palliative care and the end of life, however, lack of lesson that covers all palliative care 2) Experimental part, which is teaching in the laboratory by allowing students to practice in the situation a simulation in a nursing demonstration room using demonstration methods by case scenario.3) the practical application, which is the focus for students to lead theoretical knowledge to apply is used to effectively serve individuals, families, and communities by allowing students to practice Acting in real situations with patients in hospitals, nursing homes, health centers, and communities to gain experience in providing services (Ministry of Public Health, Lao People's Democratic Republic 2014). Nursing students, who will eventually become nurses, should be well-educated in order to

provide high-quality palliative care. In general, a critical barrier to providing palliative care is a lack of understanding.(Al Qadire 2014)

1.3 The Laos Palliative care.

Palliative care in Laos. Some pain relievers, such as morphine, have been refused by the government due to concerns about drugs being sold to addicts, the problem of advanced cancer patients who have decided to return home when treatment is ineffective, and as a result, nurses and doctors lack experience in seeing patients in terminal care. People believe that when death occurs, their spirits do not wander searching for a way back home, based on religious and traditional beliefs. ("Cancer Treatment in Laos" 2017). The patient has been in chronic sickness, endured cancer, older people, and the end of life with particular care, which Laos did not have public service hospice care that all of these issues require long term medical treatment and terminal care. Patients can be admitted to acute care hospitals, but in these cases, people are discharged, and family members are responsible for caring for patients and continuing therapy with traditional medicine at home for palliative care until death. (Kongsap Akkhavong, 2014). According to a research study on palliative care with cancer in Asia, the majority of cancer patients' diagnoses in Asian countries have advanced disease, which can cause late treatment. Supportive care refers to pain relief for cancer patients and improving the quality of life for survivors until a dignified death. (Payne et al. 2012). It is understood that situations vary significantly at the country level. Palliative care is viewed differently by different cultures and traditions. The structures of existing

healthcare systems, into which palliative care services must fit (Sepúlveda et al. 2002). Two of the most major hurdles to enhancing terminally ill patients' access to high-quality care are physicians' overestimation of patient prognosis and a shortage of palliative care staff (Avati et al. 2018). which was primary care must be developed to meet the needs of dying people. (Murray et al. 2004). The lack of personnel and training programs, as well as insufficient research funding, will continue to be important roadblocks. (Hughes and Smith 2014).

1.4 Palliative care theory.

Palliative care is a strategy for enhancing the quality of life of patients and their families who are dealing with a life-threatening illness by preventing and alleviating suffering through early detection, treatment of pain, and other physical, psychosocial, and spiritual issues (world health organization 2020). Similarly, Hospice care is end-of-life care offered by health professionals and volunteers in which caregivers aim to control pain and other symptoms, provide psychological and spiritual support. (“Global Atlas of Palliative Care at the End of Life” 2014), Furthermore, nurses' attitudes regarding caring for the dying have an impact on palliative care quality (Cevik and Kav 2013). These focus on care, pain management, comfort, and quality of life. Palliative care is a type of specialist medical care for those who have a chronic or severe illness (“What Are Palliative Care and Hospice Care?” n.d.). The key palliative approach to symptom management requires oncology doctors and palliative care specialists to advance care planning in cancer survivors and those at high risk of recurrence and mortality,

ideally through continued follow-up (Dy, Isenberg, and Al Hamayel 2017). From pre-diagnostic to diagnosis and treatment, continued illness or death, and grief, supportive cancer care is what helps the patient and their family cope with the disease and its treatment.(Watson et al. 2019) Palliative care services combine the experience of a multidisciplinary team of specialists, including doctors, nurses, and social workers.(Kelley and Meier 2010)

Palliative care is centered on the patient rather than the disease, accepts death while simultaneously extending life, is a collaboration between the patient and caregivers, and is concerned with healing rather than curing. The three essential components of palliative care (Twycross 2003)

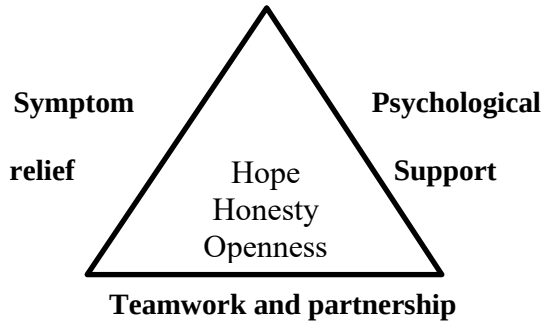

Figure. 1 Palliative care theory model.

Terminal care was related to the quality of life which if could provide early screening by professional team those patients with needs it can be most powerful (Gaertner et al. 2017), The American Academy of pediatrics palliative care services be developed and made widely available based on child-specific criteria and standards. Guides how to respond to requests for hastening death, but opposes physician-assisted suicide or euthanasia for children.(Committee on Bioethics and Committee on Hospital Care 2000). By studying sickness trajectories at the end of

life, patients and their caregivers might better understand their situation (Murray et al. 2005). Nevertheless, the community-based palliative care model connects smoothly to inpatient care and encompasses a variety of inpatient and outpatient settings (Kamal et al. 2013). The majority of Americans with serious illnesses do not die alone and in pain; they live at home, in assisted living facilities, or nursing homes, with limited access to palliative care. (Meier et al. 2017). Additionally, Geriatric hospice care should be characterized as a multidisciplinary subject of treatment and research based on the two's linkages as well as care ethics. (Voumard et al. 2018) Based on Palliative care teams that have a wide range of skills that can help patients and their caregivers with a variety of issues including end of life care.(Hui et al. 2018)

1.5 Self-efficacy theory.

Self-efficacy, or a person's sense of self-responsibility, is the ability to set high objectives for oneself and persevere in the face of obstacles that they see as challenges rather than threats. It is a significant factor in acquiring, progressing, and achieving professional skills and competencies. (Bundura 1977). Self-efficacy was a theoretically and practically based strong motivating belief that has played an important part in the acquisition of new skills and information. (Klassen and Klassen 2018). which self-efficacy for coping with cancer with a large effect of dealing with cancer treatment that shown extremely efficacious people exhibit less anxiety and better adaption in stressful circumstantial which self-efficacy is positively associated to the quality of life (Chirico et al. 2017). that nurses who

have a high level in self-efficacy score were the strongest to overcome problems, exhaustion, and loss of motivation (Consiglio et al. 2014), In cancer patients receiving chemotherapy through a peripherally placed central catheter, the self-efficacy intervention improves self-management and minimizes problems. (Liu et al. 2021)and has been related students in long-term palliative care rotations are more likely to acquire Burnout, which is associated with strong self-efficacy and a reduced intent-to-leave. (Chachula 2021). Consequently, achievement motivation, job happiness, and the intention to stay in a career were all linked to self-efficacy (Masoudi Alavi 2014). Moreover, peer learning is an effective strategy for increasing nursing students' self-efficacy, outperforming traditional supervision (Pålsson et al. 2017). Nursing educators can use self-efficacy to better identify the effects of their educational interventions and their students' actual educational requirements.(Hernández-Padilla et al. 2016) that Self-efficacy is a person's belief in their own ability to achieve in a certain situation. This is also regarded to be a key factor in palliative nursing success (Desbiens, Gagnon, and Fillion 2012). It contributes greatly to achieving goals, fulfilling obligations, and overcoming obstacles (Kohno et al. 2010). In research, self-efficacy is a useful concept: It's been added as a dimension of the Healthcare Professional Humanization Scale.(Pérez-Fuentes et al. 2019) as the sphere of healthcare, this concept is critical for nurses, who play a vital role in promoting the community's health (Cevirme et al. 2020).

1.6 Literature review.

Palliative care focuses on recognizing the needs of people who are suffering from life-threatening illnesses from a comprehensive approach (Sjöberg et al. 2021) are intended to improve care for cancer patients and their caregivers throughout the disease process (Hui and Bruera 2020) as terminal care can increase the quality of life for those who are nearing the end of their lives (Maciver and Ross 2018). which was palliative therapies started soon after a diagnosis of incurable advanced cancer may improve symptom and disease control more effectively (Levy et al. 2016) to encourage the personhood of patients with advanced cancer, advance care planning is critical. Health care workers may encourage patients to express what is important and provide meaning to them as they live, cope, and get cancer treatment (Agarwal and Epstein 2018). Future nurses must be provided with the information and abilities necessary to offer palliative care (Gelegjamts et al. 2020). These have become increasingly important in nursing care as a result of the growing number of people who undergo assistance in their final stages of life (Etafa et al. 2020). Nurses are there at both the beginning and end of life, this duty is viewed as one of the most difficult aspects of nursing because death is an inescapable phenomenon that touches every human being (Harding et al. 2010). Nurses' expertise was linked to their level of education, experience caring for chronically sick people, and experience caring for dying family members (Morita et al. 2006). According to, a health worker who reported low self-efficacy toward dying patients and their families, implying that palliative education for health care

workers should focus on expanding nursing experience as an oncology nurse and conducting expertise in end-of-life care (J. S. Kim, Kim, and Gelegjamts 2020). Health care providers would be able to overcome hurdles and improve patient care if we had a better grasp of the impact of attitudes regarding end-of-life care on quality care (Hui et al. 2016). In end-of-life care, nurses can play an important role. As a result, it is critical to examine nurses' knowledge, attitude, and practice to assist them in dealing with such situations (Kassa et al. 2014) as well as a nursing student to respond successfully to the complexity of caring for persons with a progressing, life-limiting illness, adequate knowledge of palliative care and positive attitudes toward death and dying are critical educational factors to consider (Dimoula et al. 2019). Despite feeling unprepared and nervous about talking with terminally ill patients, their families, and bereaved relatives (Bailey and Hewison 2014). While, most nursing students illustrated positive views toward death and caring for the dying, they lacked knowledge and self-efficacy in palliative care, indicating the need for palliative care instruction to be integrated into the nursing curriculum in China (Zhou, Li, and Zhang 2021). As a result, Simulation is a possible alternative to clinical experience in the absence of clinical exposure to help students prepare for their professional role in end-of-life care (Lewis et al. 2016). when we look at the effectiveness of end-of-life educational programs in changing nurses' and nursing students' attitudes toward death and the treatment of dying patients (Chua and Shorey 2021). A course in palliative care should be required in nursing school, and it should involve learning activities (Berndtsson, Karlsson, and Rejnö 2019). which Nursing education should include

a greater emphasis on death, dying, and end-of-life care in the core nursing curriculum, theory, and clinical courses (Zahran et al. 2022). it is can be successful, the public, patients, and health care providers must all be educated (Zimmermann et al. 2016).

1.7 Scope of the study.

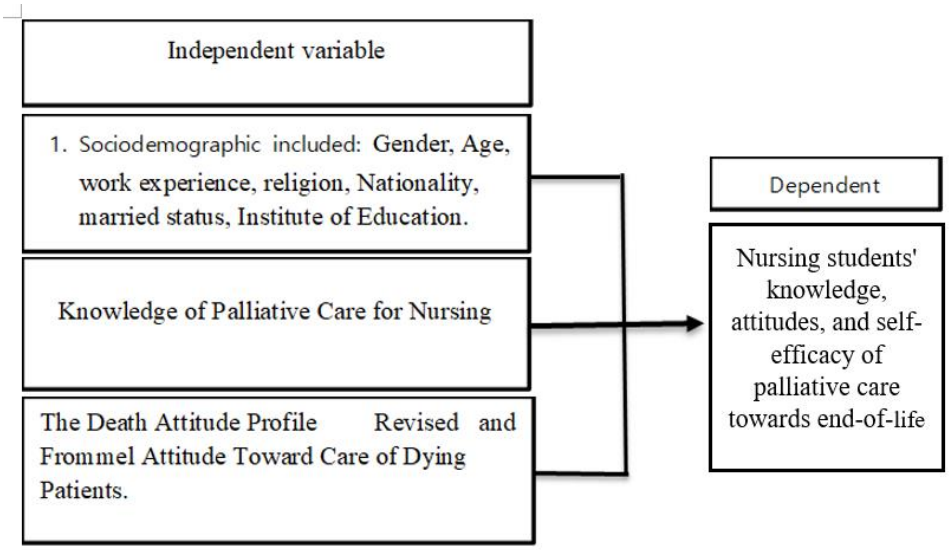

Figure. 2 scope of the study.

1.8 Research questions

1) What are the levels of palliative care, knowledge, and self-efficacy of nursing students?

2) What are the nursing students' attitudes towards death and caring for dying patients?

3) Are there any relationships between palliative care knowledge, self-efficacy, attitudes towards death, and caring for dying patients?

1.9 Objective

This is to provide better basic data for end-of-life nursing to nursing students in Laos. The specific objective is as follows.

1. To investigate higher diploma nursing students' knowledge about palliative care and attitudes towards death and end-of-life care and explore demographic and academic factors as potential moderators of student knowledge.

2. Identify the differences in knowledge of palliative care, self-efficacy, and the end-of-life nursing attitude recording to the general characteristic of nursing students.

3. Identify the correlation between knowledge of palliative care, self-efficacy, and the end-of-life nursing attitude of nursing students**.**

4. We intend to use this as the basic data for introducing the end-of-life nursing education program for nursing students in Laos.

1.10 The necessity of this study

The following are some of the reasons why the research is crucial:

a. **The University of Health Sciences (UHS) is based on the Ministry of Public Health (MOH)** and, in particular, the Laos Regional School of Nursing. It will provide nursing students in Laos with a comprehensive understanding of palliative care knowledge, attitude, practice, and other related factors, which they can use to develop a new curriculum and project training course for the development of more significant palliative care for the end-of-life of patients.

b. **The health practitioners**, especially nurses, nursing students, and other associated healthcare workers are among the health practitioners. They can utilize the data to measure their practice's performance and apply it to help critical patients, oncology patients, and terminal patients in palliative care function effectively.

c. **The school of nurses or colleges who practice with patients and will become professional nurses in the future of Laos**. The audit would serve as a foundation for improving their institution's knowledge, attitude, and practices in terms of improving palliative care for patients and their families.

d. **Future Researchers and Authors.** This study would help future research on palliative care and end-of-life care among nursing students by providing a description for assessing knowledge, attitude, self-efficacy, practices, and other associated characteristics of palliative care to patients in Laos. It can also be used as a baseline to assist other institutions in valuing understanding of nursing students and health care professional conditions which can contribute to development on social, economic, and political levels.

2. Method

2.1 study design

This was a descriptive, cross-sectional survey. A questionnaire was employed to carry out the research study on the respondents using a systematic random sample procedure. Age, gender, region, nationality, married status, practice experience, academic year, and institute both were independent variables. Nursing students' knowledge, attitudes, and self-efficacy practices of palliative care towards end-of-life have been the dependent variables.

2.2 study population

Laos is a landlocked country situated in Southeast Asia on the north-western part of the Indochinese Peninsula. It is located in the Northern and Eastern hemispheres of the Earth. Land Area: 236,800 km^2, Laos' population was estimated at about 7.06 million in 2018, Population density: 30.72 persons/km2 dispersed unevenly across the country. Most people live in valleys of the Mekong River and its tributaries. Laos is bordered by five countries. It is bounded by Myanmar

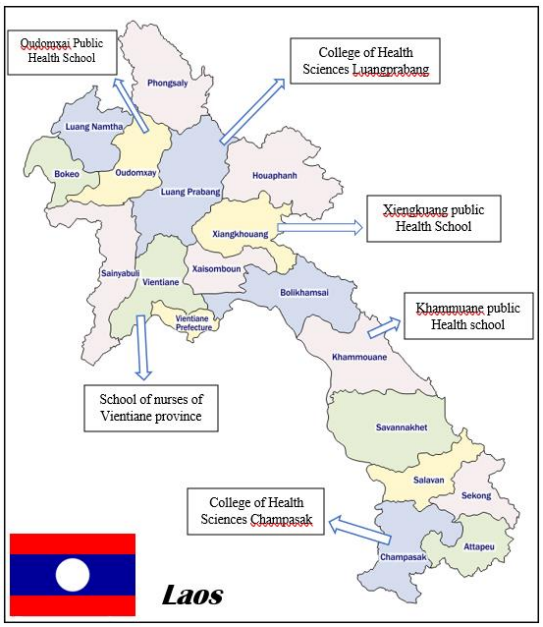

Figure. 3 Map of Laos showing geographical location of school of nurses

(North-western) and China to the northwest; by Cambodia to the south; by Vietnam to the east and by Thailand to the west. there are 18 provinces and capital city in Vientiane. In Lao People's Democratic Republic total number of new cancer case is 9,133 base on issues the ministry of Health distributed health care system comprises three administrative levels: central, provincial, and district. Especially, Health centers, village health volunteers, community health committees, and traditional birth attendants are all part of a fourth level under the districts that is Responsible for delivering community health services. ("Policy_on_primary_health_care-Eng.Pdf" n.d.).

1) Geography spread hospital:

The Ministry of Health oversees multiple tertiary care hospitals, a national center for medicine, medical colleges, and universities at the national level. In terms of technical oversight, organizational management, payroll, and operations, provincial governments supervise Provincial Health Offices. In terms of technical direction, monitoring, and inspection, Provincial Health Offices are also under the jurisdiction of the Ministry of Health. There are 18 Provincial Health Offices (including Vientiane) ,16 provincial hospitals,143 districts hospital and operates around 1,000 health centers ("Laos Health Strategy 2019-2023" 2019).

2) University of Health Sciences and college or school of nurse:

Educational institutions of nursing under the Ministry of Health in the People's Democratic Republic of Laos have a total of 08 locations across the country, spreading in every region.1) there is one University of Health Sciences, Faculty

of Nursing 2). College of Health Sciences consists of 3 colleges: College of Health Sciences Savannakhet, College of Health Sciences Champasak, and College of Health Sciences Luang Prabang 3). The school consists of 4 places, namely School of Nurses of Vientiane, Khammuane Public Health School, Xiengkuang Public Health School and Oudomxai Public Health School (Ministry of Public Health, Lao People's Democratic Republic 2014).

The researcher selected six nursing schools to take account 75 % of nursing schools or College of Health Sciences in Laos, the total number of nursing students in each school of the nurse is 150 nursing students and data collected from different regions is shown on the map (figure 3), this is total number of students in 3rd year of each nursing school is 50 students however, researchers have targeted only 44 or 45 students for collecting data consist of the School of Nurses of Vientiane Province in Vientiane Province, on the one hand, at the southern of Laos the Khammuane Public Health School in Khammoun Province, and the College of Health Sciences Champasak in Champasak Province (Pakse). On the other side, the Xiengkuang public health school in Xiangkhouang province, the Oudomxai public health school in Oudomxai province, and the College of Health Sciences Luangprabang in Luangprabang province were all established in northern Laos (figure . 4).

06 school of nurse	population	sample size
School of Nurses of Vientiane Province	50	44
Khammuane Public Health School	50	45
College of Health Sciences Champasak	50	45
Oudomxai public health school	50	45
Xiengkuang public health school	50	45
College of Health Sciences Luangprabang	50	45
Total	300	269

Figure. 4 selected 6 school of nurse's 3rd grade in Laos.

2.2.1 Study Subject

We decided to take advantage of a convenient sampling procedure. A total of 269 higher diploma of nursing students at the end of the third year of education in different six schools of nurses consist of Khammuan public Health school, Oudomxai public health school, Xiengkuang public health school, Collage of Health Sciences Champasak, College of Health Sciences Luangprabang, School of Nurse Vientiane province which is located differently provinces of Laos.

2.2.2 study sample size

The number of samples in the study is G*Power 3.1.9 Program is used to calculate. As a result of setting the Effect size 0.25 and α.05, power 0.8, and 6 groups. the sample size is 269, and 300 people to distributed in consideration of the dropout rate of 10-15%. An estimated 300 participant at the end of third year of education, higher diploma of nursing at six school of nurses in Laos.

2.3 instruments of the study

The Knowledge, Attitudes, and Palliative Care Self-Efficacy survey is a quantitative approach for acquiring quantitative and qualitative data (Nakazawa et al. 2009). There were five elements to the questionnaires utilized in this study:

Section one: Students' age, gender, academic year, practice experience, ethnicity, and marital status were all collected using a demographic questionnaire.

Section two: The knowledge questions were adopted from the Palliative Care knowledge test questions for instance “Morphine is the standard used to compare the analgesic effect of other opioids” were modified according to the prevailing context of health institutions in Laos. The Palliative Care Quiz for Nursing (PCQN) was created by Ross et al. (M Ross, McDonald, and McGuinness 1996) and is widely used to measure palliative care knowledge the English version of the original instrument was translated into Korean by a Korean nursing doctoral Hyun sook Kim at el. (H. Kim et al. 2011). The PCQN-L did not differ significantly from the original PCQN. The PCQN-L comprises 20 items divided into three subscales: palliative care philosophy (4 items), pain and symptom control (13 items), and psychosocial and spiritual care (3 items). For each item, respondents select "true," "false," or "don't know." Researchers gave a 1 for a true answer and a 0 for a wrong or "don't know" response. The PCQN-L has a total score range of 0–20. The internal consistency reliability of the PCQN-L as measured by KR-20 was 0.74 in this study.

Section three: Death Attitude Profile-Revised (DAP-R-L) Wong et al. (1994) developed the DAP-R, which is commonly used to examine respondents' attitudes toward death. The DAP-R is divided into five subscales with a total of 32 items. Fear of death is a scale that measures a person's negative feelings and thoughts about dying (7 items: 1, 2, 7, 18, 20, 21 & 32). The respondent's attempts to avoid

thinking about death are measured by death avoidance (5 items: 3, 10, 12, 19 & 26). The respondent's neutral acceptance demonstrates that death is a natural part of life and that he or she neither welcomes nor fears death (5 items: 6, 14, 17, 24 & 30). The term "approach acceptance" refers to a person's perception of death as a means to a better afterlife (10 items: 4, 8, 13, 15, 16, 22, 25, 27, 28 & 31). Finally, escape acceptance denotes. (Wong, Reker, and Gesser 1994), DAP-R used a 7-point Likert Scale, Scores for all items are from 1 to 7 in the direction of strongly disagree (1) to strongly agree (7). A mean scale score can be computed for each dimension by dividing the total scale score by the number of items forming each scale. The DAP-R-subscale C's reliability was investigated in this study, with Cronbach's alpha coefficients in Laos version is 0.93.

Section four: The Frommelt Attitudes Towards Care of the Dying (FATCOD) (Frommelt, 1991). These were examined Students' attitudes regarding caring for dying patients The results of thirty questions are added together to get a total FATCOD score, which 5-point Likert scale is used in the FATCOD-L. Positively worded items are graded on a scale of 1 (strongly disagree) to 5 (strongly agree). Higher scores indicate more positive attitudes. In this investigation, the FATCOD has excellent internal consistency (Cronbach's alpha = 0.92)

Section five: Palliative Care Self-Efficacy Scale (Phillips, Salamonson, and Davidson 2011) were used to assess palliative care self-efficacy. This scale comprises two subscales: psychological support (6 items, items 1–6) and symptom management (6 items, items 7–12), which measure respondents' perceived abilities to give palliative care. This is a four-point scale, with one

indicating "needs more basic teaching," two indicating "confident to complete with close supervision," three indicating "confident to finish with minimum consultation," and four indicating "confident to complete independently." Each palliative care task is rated according to the respondents' confidence in their ability to accomplish it. This study used the traditional forward-backward approach to translate the Palliative Care Self-Efficacy Scale into Lao. The content of the Lao version of this scale was then examined by a professor in the faculty of nursing sciences, University of Health Sciences in Laos. Cronbach's alpha of the Lao version of the Palliative Care Self-Efficacy Scale is 0.87

A panel of experts from the National Cancer Center-Graduate School of Cancer Science and Policy in South Korea, as well as the Laos Review Board Research Ethics, conducted a pilot study to determine the clarity of questions, the effectiveness of instructions, completeness of response sets, the time required to complete the questionnaire, and success of data collection techniques for the current study. The questionnaire was validated using an English language instrument that was translated into Lao languages.

2.4 Operational Definition

Variable	Questions	points	Method	explanation	source
Demographic	9	N/A	Scalar-scoring method.	age, gender, academic year, practice experience, ethnicity, and marital status.	Not applicable. (N/A)
Knowledge of palliative care	20	0-20	3-item Likert scale ranging True = 01 False = 0 don't know =0	Added together to get a total score Total scores might range from 0 (lowest degree of knowledge) to 20 (highest level of knowledge)	Margaret. Ross et al. (1996)
Attitudes toward death	32	5-35	7-item Linkert scale ranging from strongly disagree to strongly agree	For each dimension, a mean scale score can be computed by dividing the total scale score by the number of items forming each scale.	Wong, P.T.P., Reker, G.T., & Gesser, G. (1994).
Attitudes regarding caring for dying patients	30	30-150	5-point Likert scale. graded on a scale of 1 (strongly disagree) to 5 (strongly agree)	Favorable Attitude = ≥ 50% of total score of the Frommelt Attitude Toward Care of the Dying [FATCOD] scale Unfavorable Attitude = ≤ 50% of total score of the Frommelt Attitude Toward Care of the Dying [FATCOD] scale	Frommelt,1991; Frommelt, 2003
Self-efficacy	12	12-48	4 point Likert scale. (1) need further basic instruction. (2) confident to perform with close	This 12-item scale has two theoretically distinct subscales related to perceived capabilities to provide: (1) psychosocial support (6 items, numbers 1–6); and (2) symptom management (6 items, numbers 7–12). higher scores indicate	Phillips. et al (2011)

			supervision/ coaching. (3) confident to perform with minimal consultation. (4) confident to perform independently.	a higher perceived capacity toward palliative care.	

2.5 Data collection and quality control

Data collectors were given a two-day workshop on questionnaire concerns (including the study's goal, how to contact participants, and how to present and collect the questionnaire in a timely manner). The development of relevant instruments as well as human resources, such as helpers, were certainly important in completing this research effectively. During the distribution and data collection phases, the study participants' confidentiality was maintained. Above all, integrity and entry were upheld throughout the procedure.

For the sake of simplicity and to account for non-response rates, the survey included all nursing students at the completion of their third year of education in the selected school's six nursing schools. The electronic questionnaire was created by the researcher using the kobotoolbox application. A total of 300 questionnaires were distributed to the contact people using a link from https://kf.kobotoolbox.org/#/forms (Figure 5). The questionnaires were emailed to the contact individuals with a description of the study's objectives, the contact person's name, and a two-week deadline for completion, and then the surveys were submitted online. After two weeks, a reminder was received.

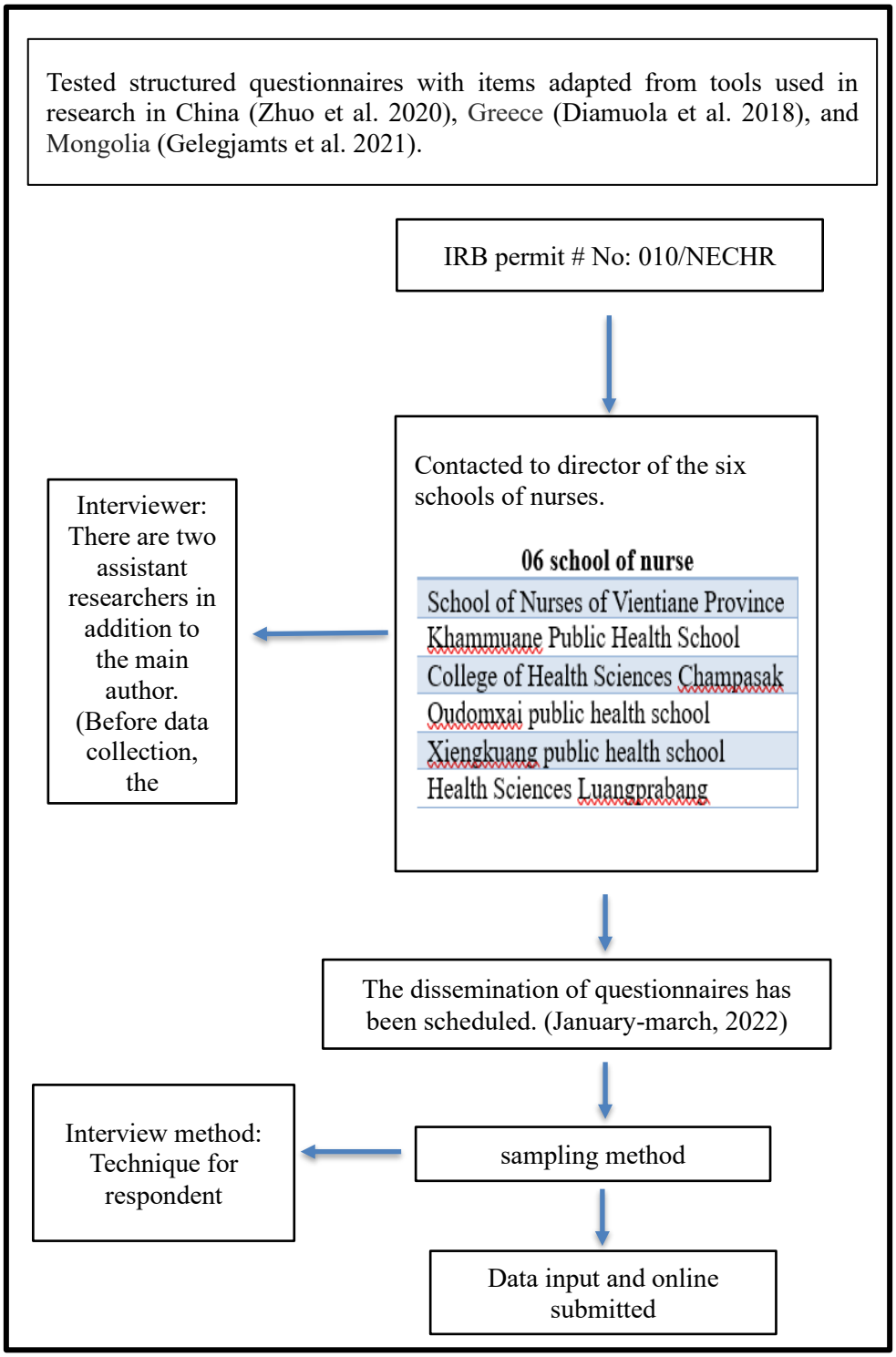

Figure. 5 Data collection flow.

2.6 Administration of Questionnaires

By appointment, the participating higher diploma nursing students were approached directly. They signed a written informed consent form. There were five sections to the questionnaires: demographic information, knowledge, attitude, and self-efficacy.

2.7 Statistical analysis

The information was entered into an Excel spreadsheet. The Stata program (version 15.1) was used for data analysis, and statistical analysis methods included analyzing the participants' general characteristics as real numbers, percentages, mean and standard deviation, total score, average, and standard deviation, and Pearson's correlation coefficient are utilized for post-analysis.

2.8 Ethical Consideration

This study was approved by the Laos-International Review Board /the National Ethics Committee for Health Research (The NECHR) with a research permit number no.010/NECHR. This was highlighted with the investigator's authorization to use the nursing students' targeted diploma curriculum. The student's consent was acquired. Prior to the presentation of the questionnaire, written informed consent was obtained. The nursing students were informed about the study's goal and that they had the option of declining to participate. The need for secrecy was again emphasized, as was the voluntary nature of involvement. The respondents' identities were kept anonymous at all times.

3. Results

3.1 Characteristics of the study participants

The G*Power 3.1.9 Program is used to calculate the number of samples in the study. As a result of the sample size being set, there are 269 higher diploma nursing students with a 100% response rate. The majority of the participants in the study were women (82.2%), with only 17.8% being men. Nearly a quarter (24.9%) of nursing students are under the age of 20, while 75.0 percent are over the age of 20. Besides Only 15 (5.6 %) had married of the 254 students (94.4 %) indicated that they were single. The most of them (80.3 percent) had less than two years of practical experience and the remainder had more than two years (19.0 percent). Overall, 74.0 percent of the participants believed in Buddhism, 23.8 % in Ghosts, and 2.2 % in Christine, according to the respondents' institute of education showed that Khammuan public Health school 14.5 %, Oudomxai public health school 17.1%, Xiengkuang public health school 16.4%, and respectively, 15.6% illustrated to School of Nurse Vientiane province, 20.8% from College of Health Sciences Champasak and 15.6% come from College of Health Sciences Luangprabang (Table 1).

Table 1: Characteristics of the study participants (N= 269)

Characteristics	Categories	N	%
Gender	Male	48	17.8
	Female	221	82.2
Age(year)	≤20	67	24.9
	>20	202	75.0
practical experience(year)	≤2	216	80.3
	>2	53	19.7
Religion	Buddhis	199	74.0
	Christine	6	2.2
	Ghost	64	23.8
Marital status	Single	254	94.4
	Married	15	5.6
Institute of education	Khammuan public Health school	39	14.5
	Oudomxai public health school	46	17.1
	Xiengkuang public health school	44	16.4
	School of Nurse Vientiane province	42	15.6
	College of Health Sciences Champasak	56	20.8
	College of Health Sciences Luangprabang	42	15.6

3.2 Knowledge of palliative care by item in nursing students

On the Palliative care quiz for nursing score (PCQN-L), the mean total knowledge score was 13.16 (SD 3.73), with a range of 0–20, and the average correct rate of knowledge was 73.4 %, demonstrating that nursing students had a better understanding of palliative care. The category with the moderate number of accurate answers on the PCQN-L was pain and symptom management (61.02 %), and the category with the highest percentage of correct responses was psychosocial and spiritual care (76.82 %) (Table 2). The most correct answers were for item 1 "Palliative care is only appropriate in situations where there is evidence of a downhill trajectory or deterioration" while the fewest correct

answers were for item 13 " The use of placebos is appropriate in the treatment of some types of pain."

Table 2. The result of the Knowledge of palliative care quiz for nurse in nursing students

Item	Correct		correct rate
	n	(%)	
Philosophy and principle of palliative care			**73.04%**
1. Palliative care is only appropriate in situations where there is evidence of a downhill trajectory or deterioration.	266	84.01	
9. The provision of palliative care requires emotional detachment.	211	78.44	
12. The philosophy of palliative care is compatible with that of aggressive treatment	162	60.22	
17. The accumulation of losses renders burnout inevitable for those who seek work in palliative care.	187	69.52	
Management of pain and symptoms			**61.02%**
2. Morphine is the standard used to compare the analgesic effect of other opioids.	189	70.26	
3.The extent of the disease determines the method of pain treatment	205	76.21	
4. Adjuvant therapies are important in managing pain	220	81.78	
6. During the last days of life, the drowsiness associated with electrolyte imbalance may decrease the need for sedation.	147	54.65	
7. Drug addiction is a major problem when morphine is used on a long-term basis for the management of pain.	161	59.85	
8. Individuals who are taking opioids should also follow a bowel regime.	142	52.79	
10. During the terminal stages of an illness, drugs that can cause respiratory depression are appropriate for the treatment of severe dyspnea.	166	61.71	

13. The use of placebos is appropriate in the treatment of some types of pain.	89	33.09	
14. In high doses, codeine causes more nausea and vomiting than morphine.	159	59.11	
15. Suffering and physical pain are synonymous	179	66.54	
16. Demerol is not an effective analgesic in the control of chronic pain	132	49.07	
18. Manifestations of chronic pain are different from those of acute pain.	224	83.27	
20. The Pain threshold is lowered by anxiety or fatigue.	121	44.98	
Psychosocial and spiritual care			**76.82%**
5. It is crucial for family members to remain at the bedside until death occurs.	220	81.78	
11. Men generally reconcile their grief more quickly than women.	196	72.86	
19. The loss of a distant or contentious relationship is easier to resolve than the loss of one that is close or intimate.	204	75.84	

3.3 Mean scores on the Death attitude profile-revised (DAP-R-L) scale

On the mean, students had a total score of 3.94 (SD=0.23) ranging 3.13-4.62 for their attitudes about death. The result was illustrated in Table 3.

Table 3. Mean scores on the Death attitude profile-revised (DAP-R-L) scale

Item	Mean	SD
1. Death is no doubt a grim experience	4.80	2.08
2. The prospects of my own death arouse anxiety in me	3.80	2.04
3. I avoid death thoughts at all costs	3.42	2.03
4. I believe that I will be in heaven after I die.	4.04	1.86
5. Death will bring an end to all my troubles.	3.70	2.10
6. Death should be viewed as a natural, undeniable, and unavoidable event	2.43	1.87
7. I am disturbed by the finality of death.	4.43	1.75
8. Death is an entrance to a place of ultimate satisfaction.	3.35	1.83
9. Death provides an escape from this terrible world.	4.00	1.90
10. Whenever the thought of death enters my mind, I try to push it away	5.00	1.82
11. Death is deliverance from pain and suffering.	4.84	1.89
12. I always try not to think about death.	3.05	1.84
13. I believe that heaven will be a much better place than this world	4.16	1.82
14. Death is a natural aspect of life	2.43	1.66
15. Death is a union with God and eternal bliss	4.16	1.74
16. Death brings a promise of a new and glorious life	4.46	1.78
17. I would neither fear death nor welcome it	3.53	1.96
18. I have an intense fear of death	4.70	1.94
19. I avoid thinking about death altogether	4.60	1.87
20. The subject of life after death troubles me greatly.	4.01	1.78
21. The fact that death will mean the end of everything as I know it frightens me.	3.49	1.87
22. I look forward to a reunion with my loved ones after I die	3.81	1.94
23. I view death as a relief from earthly suffering.	3.82	1.91

24. Death is simply a part of the process of life.	3.13	1.78
25. I see death as a passage to an eternal and blessed place	4.23	1.80
26. I try to have nothing to do with the subject of death.	4.60	1.78
27. Death offers a wonderful release of the soul	4.28	1.82
28. One thing that gives me comfort in facing death is my belief in the afterlife	4.04	1.81
29. I see death as a relief from the burden of this life.	3.40	1.91
30. Death is neither good nor bad.	3.21	1.84
31. I look forward to life after death	4.90	1.86
32. The uncertainty of not knowing what happens after death worries me.	4.50	1.76
Total	**3.94**	**0.23**

Note. SD=Standard division

3.4 Mean scores on the Death attitude profile-revised (DAP-R-L) subscales

Mean subscales scores remarkable on the 3 subscales with high scores was Fear of Death was 4.23(SD=0.57), Approach Acceptance was 4.14 (SD=0.48), and avoidance of death was 4.11(SD=0.64), Meanwhile, as can be seen in (Table 4), the percentages of Escape Acceptance 3.95 (SD=0.66) and Neutral Acceptance 2.95 (SD=1.25) have also declined at the period of time.

Table 4. Mean scores on the Death attitude profile-revised (DAP-R-L)

Scale	Subscales	Mean	SD
DAP-R-C	Fear of Death	4.23	0.57
	Death Avoidance	4.11	0.64
	Neutral Acceptance	2.95	1.25
	Approach Acceptance	4.14	0.48
	Escape Acceptance	3.95	0.66

Note. DAP-R-C= the Laos version of the Death Attitude Profile-Revised, SD= Standard division.

3.5 The Frommelt Attitude Toward Care of Dying Scale (FATCOD)

As a result, the vast majority of the students examined did not consider death to be a normal part of life. With a range of 69–125, students' overall FATCOD-C mean score for attitudes about caring for dying patients was 91.87 (SD 9.44). The proportion of students (N = 152, 56.50 %) has a negative attitude toward caring for dying patients, according to the cut-off criteria of less than 50%. On the other hand, less than half of the students (N=117, 43.49 %) are enthusiastic about caring for patients.

The mean score on eleven of the thirty categories (3, 6, 8, 9, 10, 14, 12, 19, 26, 28, 29) was less than three, showing negative views among students5). Significantly, of the four items (3, 8, 14, 26) We did notice some student uneasiness, particularly when it came to direct care of a dying person and dealing with questions and emotional emotions related to an impending death. The remaining (19) FATCOD-C measures had mean scores of 3.01–3.86, showing neutral-to-moderately positive sentiments among students. List the ranking of items with high average score, item among of the top 5 priorities, that is listing it a ranking of 1, 4, 16, 18 and 21. On the other hand the three items that had the lowest ranking were item 12 “The family should be involved in the physical care of the dying person.”, item 11 “When a patient asks, “Am I dying?” I think it is best to change the subject to something cheerful”, and item 3 “I would be uncomfortable talking about impending death with the dying person”.

Table 5. The Frommelt Attitude Toward Care of Dying Scale (FATCOD)

Scale item	Mean	SD
1. Giving care to the dying person is a worthwhile experience.	3.86	1.11
2. Death is not the worst thing that can happen to a person.	3.56	1.15
3. I would be uncomfortable talking about impending death with the dying person	2.55	1.19
4. Caring for the patient's family should continue throughout the period of grief and bereavement	3.73	1.14
5. I would not want to care for a dying person.	3.48	1.39
6.The non-family caregivers should not be the one to talk about death with the dying person	2.71	1.30
7. The length of time required to give care to a dying person would frustrate me.	3.21	1.31
8. I would be upset when the dying person I was caring for gave up hope of getting better.	2.72	1.21
9. It is difficult to form a close relationship with the dying person.	2.74	1.18
10. There are times when death is welcomed by the dying person	2.93	1.16
11. When a patient asks, "Am I dying?" I think it is best to change the subject to something cheerful	2.27	1.23
12. The family should be involved in the physical care of the dying person	2.00	1.08
13. I would hope the person I'm caring for dies when I am not present	3.19	1.29
14. I am afraid to become friends with a dying person.	3.25	1.28
15. I would feel like running away when the person actually died	3.38	1.30
16. Families need emotional support to accept the behavior changes of the dying person	3.72	1.07
17. As a patient nears death, the non-family caregiver should withdraw from his or her involvement with the patient	3.00	1.28
18. Families should be concerned about helping their dying member make the best of his or her remaining life	3.73	1.13
19. The dying person should not be allowed to make decisions about his or her physical care.	2.90	1.27
20. Families should maintain as normal an environment as possible for their dying member.	3.70	1.06
21. It is beneficial for the dying person to verbalize his or her feelings	3.76	1.12

22. Care should extend to the family of the dying person	3.70	1.08
23. Caregivers should permit dying persons to have flexible visiting schedules	3.45	1.18
24. The dying person and his or her family should be the in-charge decision makers	3.60	1.14
25. Addiction to pain relieving medication should not be a concern when dealing with a dying person.	3.20	1.17
26. I would be uncomfortable if I entered the room of a terminally ill person and found him or her crying.	2.56	1.23
27. Dying persons should be given honest answers about their condition.	3.35	1.17
28. Educating families about death and dying is not a non-family caregiver's responsibility	2.84	1.20
29. Family members who stay close to a dying person often interfere with the professional's job with the patient	2.68	1.20
30. It is possible for non-family caregivers to help patients prepare for death.	3.32	1.20
Total	3.16	0.30

Note. SD=Standard division

3.6 The palliative care self-efficacy scale

According to the investigators, the palliative care self-efficacy scale had a mean score of 2.49 (SD: 0.67), with a range of 1 to 4 (table 6).

The mean score for the subscale " Psychosocial support" was 2.45, while the mean score for the subscale " Symptom management " was 2.54. significantly, the three items with the highest self-efficacy scores were, "Supporting the patient or family member when they become upset", "Discussing different environmental options (e.g. hospital, home, family)" and "Reacting to and coping with limited patient decision-making capacity." The two items with the lowest self-efficacy scores were, "Answering patient's questions about the dying process" and "Reacting to and coping with reports of constipation" (Table 7).

Table 6. The palliative care self-efficacy scale

item scale	Mean	SD
1. Answering patients questions about the dying process	2.23	1.16
2. Supporting the patient or family member when they become upset	2.57	0.97
3. Informing people of the support services available	2.56	1.04
4. Discussing different environmental options (e.g. hospital, home, family)	2.57	1.10
5. Discussing patient's wishes for after their death	2.50	1.05
6. Answering queries about the effects of certain medications	2.26	1.07
7. Reacting to reports of pain from the patient	2.51	1.02
8. Reacting to and coping with terminal delirium	2.48	1.08
9. Reacting to and coping with terminal dyspnea (breathlessness)	2.55	1.06
10. Reacting to and coping with nausea/vomiting	2.56	1.00
11. Reacting to and coping with reports of constipation	2.46	0.98
12. Reacting to and coping with limited patient decision-making capacity	2.68	1.03
Total	2.49	0.67

Note. SD=Standard division

Table 7. Mean score of the palliative care self-efficacy subscale

Scale	Subdimension	Mean	SD
Self-efficacy		2.49	0.67
	Psychosocial support (item: 1-6)	2.45	0.72
	Symptom management (item: 7-12)	2.54	0.71

Note. SD=Standard division

3.7 Correlations among Knowledge, Attitude and self-efficacy of palliative care towards end-of-life Nursing

A Pearson correlation was used to evaluate several statistically significant correlations emerged from studies of knowledge, death attitudes, attitudes toward caring for the dying, and self-efficacy in the total group (Table 8).

Noticeable, between fear of death and the Frommelt Attitude Toward Care of the Dying Scale (FATCOD-L) (r=0.344; P< 0.000) was established moderate positive and escape acceptance and Self-efficacy (r= 0.162; P< 0.007) was weak positive. further, there was a weak negative association between fear of death and approach acceptance (r = -0.131; p < 0.030), besides, there was a weak negative link between fear of death and escape acceptance (r = -0.150; P< 0.013). Similarly, there was a weak negative correlation between neutral acceptance and escape acceptance (r = -0.179; P<0.003), neutral acceptance and FATCOD-L (r=-0.215; P< 0.000), fear of death and self-efficacy (r = -0.246; P< 0.00), escape acceptance and FATCOD-L (r=-0.192; P< 0.001), Furthermore, both the (FATCOD-L) – (Self-efficacy) (r=-0.387; P< 0.000) and Neutral acceptance – Approach acceptance (r=-0.425; P< .000) correlations shown moderate negative correlations.

Table: 8 Correlations among Knowledge, Attitude and self-efficacy of palliative care towards end-of-life Nursing

			Death attitudes					
		knowledge	Fear of death	Death avoidance	Neutral acceptance	approach acceptance	escape acceptance	**FATCOD-L**
		r(P)						
knowledge		**1.000**						
Death attitudes	Fear of death	-0.013 0.821	**1.000**					
	Death avoidance	0.007 0.907	0.038 0.528	**1.000**				
	Neutral acceptance	-0.041 0.496	-0.017 0.777	-0.214 **0.000**	**1.000**			
	Approach acceptance	0.054 0.374	-0.131* **0.030**	0.044 0.463	-0.425* **0.000**	**1.000**		
	Escape acceptance	0.037 0.541	-0.150* **0.013**	0.049 0.416	-0.179* **0.003**	0.117 0.053	**1.000**	
FATCOD-L		-0.080 0.188	0.344* **0.000**	0.004 0.0944	-0.215* **0.000**	0.012 0.833	-0.192* **0.001**	**1.000**
Self-efficacy		0.069 0.255	-0.246* **0.000**	-0.001 0.984	-0.013 0.826	0.054 0.374	0.162* **0.007**	-0.387* **0.000**

Note. FATCOD-L=the Laos version of the Frommelt attitude Toward care of the Dying scale.

P values were determined by Pearson correlation test.

4. Discussions

Based on our literature, this study is a pilot study that focusing on the knowledge, attitudes, and practices of Laotian nursing students relate to palliative care. When this study was launched, there was no standardized palliative care program in Laos, providing treatment for cancer patients and those who end their lives in hospice wards.

A present study finding most of them (80.3 %) had less than two years of practical experience and the remainder had more than two years (19.0 %). though, most of the nursing students have the experience to practice for approximately 02 years, they have dealt with real patients in clinical at the hospital (80.3 %) which can be probably one of the reasons for higher scores of knowledges of palliative care than others study in nursing students. (Zhou, Li, and Zhang 2021a) In comparison to the previous study, Chinese nursing students have a lower mean score in palliative care since (77 %) do not have previous experience, whereas Greek nursing students (92 %) do not have previous experience.(Dimoula et al. 2019). Overall, 74.0 percent of the participants believed in Buddhism, 23.8 % in Ghosts (shamanism), and 2.2 % in Christine. almost nursing students in Laos believe in Buddhism which Buddhism holds that a supernatural being who created the world is in control of mankind's bliss and disaster (www.wisdomlib.org 2015). respectively, belief in Ghosts has Religion beliefs in ghosts remote from sciences Supernatural deities, deities can also be ancestral spirits or spirits of ostensibly supernatural forces. Because the spirit was released from the corporeal after death

Based on the tradition, culture, and Buddhism Religion of Laos When a cure is ineffective, they return home to die - to ensure that their souls do not wander looking for a home, there is a cremation service for the spirits for two or three days pray Buddha one time a day by monk Buddhists believe in life after death. The Wheel of Existence depicts the several places in which Buddhists believe spirits can be reborn (“Cancer Treatment in Laos” 2017), (“What Does Buddhism Teach about Life after Death? - Life after Death - GCSE Religious Studies Revision” n.d.). It is possible that this is one of the reasons why Lao nursing students have a negative attitude toward care for dying patients. The difference in a study of Chinese nursing students (Zhou, Li, and Zhang 2021), 92 % were not religious. that demonstrate positive views regarding death and care for the dying and in Greek reported positive, liberal, and supportive views about end-of-life care (Dimoula et al. 2019).

The current study found that while nursing students exhibited negative views toward death and caring for the dying, they also had a moderate degree of knowledge and self-efficacy about palliative care. The current study's findings revealed that nursing students had intermediate knowledge levels, with a mean total knowledge score of 13.16. In comparison to prior PCQN-based studies of nursing students, this score was slightly greater than the mean obtained among nursing students in Seoul, Korea. Nurses who were working in general wards and intensive care units (9.73) (S. Kim, Lee, and Kim 2020) in China (9.04)(Zhou, Li, and Zhang 2021a), but higher than the scores obtained from the second, third- and fourth-year nursing students in Greece (8.2) (Dimoula et al. 2019), nursing student in Mongolia

(7.15) (Gelegjamts et al. 2020), and the second, third, fourth and internship year nursing students in Saudi Arabia (5.23) (Aboshaiqah 2020). According to the results of the study, the reason for the low marks in the previous studies could be due to a lack of palliative care teaching in nursing programs. (Zhou, Li, and Zhang 2021), (Aboshaiqah 2020), (Dimoula et al. 2019). Furthermore, Nguyen et al. (2014) discovered that oncology nurses in Vietnam had insufficient knowledge and perceived self-competence in palliative care. The data above emphasize the importance of increasing not just nursing students' or nurses' knowledge, but also their self-efficacy in performing palliative care in future training (Nguyen, Yates, and Osborne 2014).

The current study also indicated that most students appeared to have low knowledge of the management of pain and symptoms (61.02%), which was the lowest correct rate in the PCQN-C in Laos. contradict with the correct score with the studies conducted on Wollega zones, Ethiopia nurses (Etafa et al. 2020), in Greece nursing student (Dimoula et al. 2019). Students of nursing Possible explanations for such low scores include the presence or lack of palliative care courses in Diploma nursing programs, as well as their quality. However, most students appeared to have a basic understanding of the fundamental principles of palliative care and pain management, which is somewhat reassuring. Continuing Professional Development may help to consolidate more advanced knowledge on pain/symptom management. The current findings contradict (Zhou, Li, and Zhang, 2021) and (Gelegjamts et al. 2020) studies, which revealed that the category with the lowest number of accurate responses was psychological and spiritual care,

which had the highest percentage of correct answers in Lao nursing students. This inconsistency could be explained as a result of sample differences.

For the management of nursing education in Only the nursing certificate program It has 4 curriculum structures which are a general knowledge course of 8 credits, a basic vocational course of 37 credits, a vocational nursing course of 57 credits, and elective courses of 4 credits, totaling 106 credits. The duration of study is 3 years. There is no course or subject related to palliative care or terminal care, however, only be briefly taught nursing cares for adults and the elderly for chronic and critical diseases that relate to the end-of-life care 2(2-0-0) credits and elderly nursing practical 2(2-0-8) credits in the intensive care unit. It could be due to the palliative care education is insufficient and less content is related to the pain and symptom management aspects in the educational programs (Ministry of Public Health, Lao People's Democratic Republic 2013).

Furthermore, the present study discovered that question 13 on the PCQN-L, "The use of placebos is appropriate in the treatment of some types of pain," received the fewest right answer. When compared to previous research that used the PCQN, the studies on nursing students in China (Jiang et al. 2019), and in Spain register nurses (Martínez-Sabater, Chover-Sierra, and Chover-Sierra 2021) demonstrated opposing reactions. Nonetheless, research involving nurses from two tertiary university hospitals in South Korea (S. Kim and Hwang 2014) yielded comparable results to the current study. The current study's students' inaccurate responses to question 13 could be attributed to the some pain relievers, such as morphine, have been refused by the government due to concerns about drugs being sold to addicts,

and as a result, nurses and doctors lack experience in seeing patients in terminal care (“Cancer Treatment in Laos” 2017). Nurses having only an undergraduate degree scored lower on knowledge of palliative care than nurses with a graduate school degree. This is due to the inadequate of a consistent curriculum on palliative care in formal undergraduate programs, despite the fact that it is part of the curriculum in graduate programs consistency with (S. Kim and Hwang 2014), (Zhou, Li, and Zhang 2021a), (Dimoula et al. 2019).

Regarding attitudes toward death, in the present study, most nursing students fear death. However, this result disagreed with the previous studies found that most of nursing students Approach acceptance of death in Amman, Jordan, (Zahran et al. 2022), health care providers in China (Shi et al. 2019) and nursing student in China (Zhou, Li, and Zhang 2021) believe that Death was regarded as a natural aspect of existence by all. This data, however, contradicted a recent study (Shi et al. 2019), which found that the majority of Chinese nurses and nursing students had poor scores on Escape acceptance and Approach acceptance (Zhou, Li, and Zhang 2021). The main differences between the current study and (Shi et al. 2019)'s study are that the significant number of the health care providers in (Shi et al. 2019)'s sample had experienced the death of a relative, and 87.1 percent of the health care providers who had experienced end-of-life education had previously taken a course on death and dying. In New York (Lange, Thom, and Kline 2008) Nursing experience and age were the characteristics most likely to predict nurses' attitudes toward death and caring for dying patients, despite the fact that there are certain factors influencing attitudes toward death.

The majority of students in the current study exhibited a negative attitude about caring for the dying, with an overall FATCOD-B mean score of 91.87. In comparison to earlier research assessing nursing students' views using the FATCOD or the FATCOD Form B, this score is slightly lower than that of Jordanian nursing students (FATCOD-B = 98.1) (Zahran et al. 2022), three difference country in European, Italian students (FATCOD-B= 101.8), in Spanish students (FATCOD-B= 95.1), British students (FATCOD-B = 95.3)(Ferri et al. 2021), and nursing students in the Kerala(India) (FATCOD-B= 95.81)(Paul, Renu, and Thampi 2019) However, This score, is significantly lower than that obtained in research conducted with nursing students in their first to third years in Switzerland. (FATCOD-B= 117.7)(Laporte et al. 2020)and second years Italian's medical student (FATCOD-B= 112.8)(Leombruni et al. 2012). Participants' attitudes on caring for dying patients are influenced by their education, religious beliefs, and cultural surroundings (Iranmanesh, Dargahi, and Abbaszadeh 2008), (Wang et al. 2018). This reasoning is congruent with the findings of a study conducted in the United States, which revealed a substantial association between students' ethnicity and their attitudes toward death and dying (Dunn, Otten, and Stephens 2005). Furthermore, the current study found that students had a negative attitude about direct care of dying patients. Since care for dying patients causes emotional stress and anxiety, future training courses may need to include how to prepare students cognitively to deal with the obstacles of the dying process.

There were no significant connections discovered in this study between knowledge and death attitudes, attitudes toward caring for the dying, and self-

efficacy. Consistently, Zhou, Li et al (2021) found no significant differences between knowledge with the PCQN, the DAP-R-C, and the FATCOD among undergraduate nursing students in China at the end of their third year of study. However, Dimoula et al. (2019) differently conducted a study among undergraduate nursing students in Greece using the PCQN and the FATCOD and discovered a low positive relationship between knowledge and attitudes about care for the dying. This disparity could be attributed to inequalities in palliative care education. Nursing students in Laos and China did not get mandatory palliative care education, and just a few topics related to end-of-life care were taught; whereas, students in Dimoula et al (2019)'s study got official palliative care education.

Furthermore, this differential may be due to cultural differences from western, as talking about death is forbidden in Chinese , and Lao culture which because it is regarded as disrespectful, brings bad luck, or causes despair and students may feel more stressed and unwilling to care for dying patients.

In current study discovered a considerably weak negative association between escape acceptance and the Frommelt Attitude Toward Care of the Dying Scale (FATCOD-L). Consistent with the findings of (Shi et al. 2019), a study of community health care practitioners in China. This suggests that students who escape accepting death tended to have negative attitudes toward caring for the dying (Braun, Gordon, and Uziely 2009). More crucially, escape acceptability and self-efficacy were only weakly positive, which was consistent with recent research on Chinese undergraduate nursing students. However, the correlation between fear

of death and the Frommelt Attitude Toward Care of the Dying Scale (FATCOD-L) was shown to be moderately positive in a diploma program in Laos, which differed from a recent study on Chinese undergraduate nursing students (Zhou, Li, and Zhang 2021) was weak negative correlation result. The results of this study on the cultural, religious, and experiential diversity of palliative care suggest that palliative care education should adapt to the cultural background. Currently, insufficient clinical experience in palliative care is offered in Lao diploma education. Palliative care courses may be designed in the future to improve the knowledge and skills of students providing palliative care in Laos. Nursing educators must therefore not only develop appropriate educational content but also apply a variety of teaching methodologies to facilitate active and experiential clinical learning in palliative care. Because Laos lacked public hospice care and these issues necessitated long-term medical treatment in terminal care, registered nurses only had experience in an intensive care unit, so providing palliative care courses or training was necessary to improve knowledge and attitudes toward end-of-life care with the professional nurse in the intensive care unit in Laos. This author intends to conduct further research by increasing the number of subjects for study in the future.

4.1 Strength

First and foremost, this dissertation is the first research on palliative care knowledge, attitude, and efficacy among Laotian nursing students that have never been published before the thesis Laos students. Researchers used a nursing school-based cross-sectional strategy to explore nursing students' knowledge, attitude, and self-efficacy in palliative care, as well as other variables that impact their desire to receive palliative care.

Because the research data was collected non-face-to-face, the subjects were students in areas where Internet access was available. The author involved significant cohorts from six academic institutions, which contributed to a large survey sample the total number of nursing students in nursing schools, which account for 75% of nursing schools in Laos, the total number of nursing students 150 in each school, and data were collected by region. Although the total number of students in the third year of each nursing school was 50, the researchers only targeted 44 to 45 students to collect data with obvious variation in certain categories of student characteristics due to a satisfactory response rate. Furthermore, we employed well-developed and validated questionnaires, which we translated into Lao in accordance with current standards. This method assured the internal validity of our investigation and improved the comparability of our findings with previous evidence.

As a result, we believe that the findings of this study are informative and meaningful for the development of nursing education because they will provide

comprehensive information and understanding of the knowledge, attitude, self-efficacy, and other associated factors of palliative care to nursing students in Laos, which can be used to craft policies and projects for the development of a more significant for nurses or nursing students. In the near future, it may be considered developing a plan to standardize palliative care programs**.**

4.2 Limitations

(1) Even though this study was done on nursing students in their third year of a higher diploma program, the findings may not be generalizable to all nursing students in Laos.

(2) To prevent student cooperation during questionnaire completion in the classroom, the researcher and lecturer invigilated all participating students. We cannot, however, rule out the likelihood that, to some level (minimum), student collaboration occurred, impacting our findings.

(3) Because this was a cross-sectional survey, the links between these factors could not be causal relationships.

(4) This study evaluated students' knowledge attitudes and self-efficacy rather than their actual competence or skills in practice.

(5) Due to COVID-19, we were unable to conduct face-to-face interviews with nursing students due to paper questions. It cannot be excluded that there may be some effect on the results.

5. Conclusion

The students of Lao Nursing School did not receive compulsory education in palliative care, and only a few subjects related to palliative care for chronic and serious diseases were taught. Palliative care was quite well-understood by nursing students. However, according to the cut-off criteria of less than 50%, more than half of those surveyed have a negative attitude regarding caring for dying patients. The study's findings emphasize the significance of developing nursing palliative care services in Laos. Limitations in nursing students' practice linked to delivering prescription opiate medicines to a cancer patient to treat pain may be contributing to the factor that makes the correct answer management of pain and symptoms score was low in this study. Major hurdles to providing palliative care to nursing students include a lack of research data to assist practitioners, a lack of staff training in palliative care and nursing students, and restrictive specialty palliative care service programs. Quality palliative care services, on the other hand, necessitate the education and training of health professionals in this field. Palliative care should be included in all nursing school curricula and continuing nursing education program offers. In the other word, palliative care is crucial. The author suggests applying the results of this study to improve and develop their education field, we intend to teach nursing students who will work directly in the area of nursing how to perform the delicate and difficult process of end-of-life care at nursing schools, which will serve as the basis for future palliative care in Laos.

APPENDIX

I. Questionnaires

1. Inform consent to participate in research
2. Certificate of consent
3. Research questionnaires (English)
4. Research questionnaire (Lao)
5. International Review Board Permit
6. permission to use the questionnaire from the original author

Information documents include informed consent
For volunteers more than 18 years old

The inform consent consists of two parts:
Part 1 is an inform document for research project volunteers
Part 2 is the consent document to participate in the research

Part 1
Information sheet for research project volunteers

Name of research project: Nursing student's knowledge, self-efficacy of palliative care and attitude toward end-of-life nursing in Laos.

Researcher Team: Mr. NAOVALAD Khamsone

Institution: Master of Public Health (Oncology Nursing)
National Cancer Center, Graduate School of Cancer Science and Policy

Researcher invited you to participate in this research project because you are a diploma of high Nursing program in Lao PDR. This research project selected a total of 269 participants from nursing students' diploma of high Nursing program at the end of years 3, amount of participant was from Xieng Khouang Province 45 people, Collage of Health Sciences Champasak is 45 people, Khammouane Public Health school 45 people, School of Nurse Vientane Provivce 44 people, collage of Health Sciences Luangprabang 45 people and Oudomxai Public Health school 45 people.

Before you decide to join this research project, please read this research paper carefully to understand the things that participant will be involved in the research project. If you have some questions don't hesitate to discuss with expertise that you know or ask researcher until understand.

Researchers find that the decision to participate in this study depends on your willingness to do, so. participant can refuse to participate in this research program and can withdraw without giving a reason.

What is this research project about?

This research project is a descriptive correlative study.

How you will act or be treated.

The study took about 120 minutes to complete the survey and paused for about 10 minutes during the survey, including 120 minutes.

Please sign the consent form as proof, then you will complete the questionnaire, which is divided into five sections: Part 1: Nursing Student Personal Information Questionnaire, Part 2: the palliative care Quiz for nursing, Part 3: the Death attitude profile-revised, Part 4 palliative care self-efficacy scale Researchers will be asked to answer Part 1, part 2 and Part 3 before it takes about 40 minutes to complete Part 4 and 5, respectively.

How long will you be on the research project?

Since you signed up to participate in the research project until the end of about 120 minutes.

You may be exposed to the risks or inconveniences of participating in a research project and the researcher has a way of minimizing or avoiding such risks.

Participant will have to answer a questionnaire, which includes a total of 100 questions, which may waste your personal time and frustration while answering the questionnaire. Researchers will have a way to reduce this rush by allowing you to pause for 10 minutes after answering the questionnaire. Part 1, part 2 and Part 3 actually answer the questionnaire Part 4 and Part 5 You can refuse or cancel your participation in the research project during the survey.

How will you benefit from participating in this research program?

The results of this study will provide basic information on how to improve the teaching-learning process in accordance with the learning model of nursing students. The expect outcome can promote nursing students develop knowledge to taking care chronic disease and palliative care and the end of life for patients and their families.

Participation in the research depends on your ability to do it. so, have the right to refuse to participate in the research program by telling the researcher or withdrawing from the research program without any effect or loss of benefits to you.

Keeping information confidential.

Personal information, including personal identity and information studies will be collected in paper or electronic, or both formats the information to be kept secret only while researchers can access your data to however while the research authority to reserve the data and easy to access your personal data to verify information and process research you are entitled by law to obtain personal information of you if you want to use this right, please notify the researcher and the benefits arising from the study according to the regulations of the National Cancer Center School of cancer science and policy.

The data is divided into two parts: this data obtain from research and personal information that identifies you as the number of linked code from the study will specify the data will be stored at the National Cancer graduate School of Cancer Science and Policy and was destroyed after analysis of the results of the research have been published in journal and 01 years kept during that time may be needed to confirm accurate data after the study or analysis even to stand maintaining accurate educational research.

How your information will be used and shared with whom.

The information obtained from the study will be used to summarize and report the academic report without reference to your name or anything else that identifies you. However, some journal will be had regulate personal information add to public data base for other researcher easy to excess. Researcher inform all of participants should confidential that your personal information will not identify or connect to volunteers.

You will receive costs or compensation for participating in the research program.

There is no cost or compensation for participating in this research project, but there will be a penny gift for 5,000 kip. In return for sacrificing time to answer the questionnaire, if you have any questions about this study, who can I contact?

People you can contact for more information about the study.

1. Mr. NAOVALAD Khamsone
   Faculty of Nursing, University of Health sciences
   Tel: +85620 59897475
   +8210-4463-5989 (Korea)
   E-mail: Khamsonesone2@gmail.com
   (24 hours a day)
2. PROFESSOR: SENA LEE
   Assistant Professor cancer center. Graduate school of cancer science and policy.
   E-mail: snlee0625@ncc.re.kr
   Tel: +82 010-3404-9806
   (Contact during office hours)

If you have any questions about your rights before or during your participation in the research program, you can contact the National Cancer Center Ethics Committee, Graduate School of Cancer Science and Policy (South Korea).

The interest of researcher [ ] Yes [√] None

Part 2
Letter of consent to participate in the research project

I .....Decided to participate in a research project on topic Nursing student's knowledge, self-efficacy of palliative care and attitude toward end-of-life nursing in Laos.

I have received information and explanations about this research project, I have had the opportunity to ask questions and get satisfactory answers, I have had enough time to read and understand the information in the data sheet for the participants in the research study thoroughly and have had enough time to make decisions when participating in this research project.

I acknowledge that I can refuse to participate in the program freely while participating in my research program, and may withdraw my consent at any time.

I acknowledge that the researcher will keep the information specific to me confidential and will disclose it only in the form of a summary of the findings, and that the researcher will act in a way that does not endanger my body or mind throughout this research.

By signing up, I did not waive any of my legal rights, and after signing up, I received a copy of the Notification and Consent Form.

Research Participant Signature .....Date-Month-Year .....
Full name (.....)

Signature of the researcher .....Date-Month-Year…….
Full name (.....)

N0:.....

National Cancer Center
Graduate School of Cancer Science and Policy

Questionnaire

Nursing student's knowledge, self-efficacy of palliative care and attitude toward end-of-life nursing in Laos.

I. The questionnaires used in this study included five parts consist:
   (a) part 1: Demographic questionnaire
   (b) part 2: The Palliative Care Quiz for Nursing 20 items
   (c) part 3: The Death Attitude Profile-Revised 32 items
   (d) part 4: The Palliative Care Self-Efficacy Scale 12 items.
   (e) part 5: The Frommel Attitude Toward Care of Dying Patients Scale 30 items

Part 1: Personal information:

Information: please fill in the blank and use the symbol ✓ on the box ☐ correct answer.

1. Gender: ☐ Male ☐ Females
2. Age: ☐19-20 years ☐ 21-30 years ☐ 31-40 years ☐ 41-50 years
3. Work experiences: ☐ 1-2 years ☐ 3-4 years ☐ 5-10 years
4. Year: ☐ years 01 ☐ years 02 ☐ years 03
5. Religion: ☐ Buddhis ☐ Christine ☐ Ghost ☐ others....
6. Nationality: ☐ Lao ☐ others.....
7. Marital status: ☐ Single ☐ Married ☐ Divorce ☐ others...
8. Academic years: ☐ 2020-2021 ☐ 2021-2022
9. Institute of Education:
   - ☐ Khammuan public Health school
   - ☐ Oudomxai public health school
   - ☐ Xiengkuang public health school
   - ☐ School of Nurse Vientiane province
   - ☐ College of Health Sciences Champasak
   - ☐ College of Health Sciences Luangprabang

Part 2: the Palliative Care Quiz for Nursing 20 items.

No	Content	T	F	D/K
1	Palliative care is only appropriate in situations where there is evidence of a downhill trajectory or deterioration.			
2	Morphine is the standard used to compare the analgesic effect of other opioids.			
3	The extent of the disease determines the method of pain treatment			
4	Adjuvant therapies are important in managing pain			
5	It is crucial for family members to remain at the bedside until death occurs.			
6	During the last days of life, the drowsiness associated with electrolyte imbalance may decrease the need for sedation.			
7	Drug addiction is a major problem when morphine is used on a long-term basis for the management of pain.			
8	Individuals who are taking opioids should also follow a bowel regime.			
9	The provision of palliative care requires emotional detachment.			
10	During the terminal stages of an illness, drugs that can cause respiratory depression are appropriate for the treatment of severe dyspnea.			
11	Men generally reconcile their grief more quickly than women.			
12	The philosophy of palliative care is compatible with that of aggressive treatment.			
13	The use of placebos is appropriate in the treatment of some types of pain.			
14	In high doses, codeine causes more nausea and vomiting than morphine.			
15	Suffering and physical pain are synonymous.			
16	Demerol is not an effective analgesic in the control of chronic pain.			
17	The accumulation of losses renders burnout inevitable for those who seek work in palliative care.			
18	Manifestations of chronic pain are different from those of acute pain.			
19	The loss of a distant or contentious relationship is easier to resolve than the loss of one that is close or intimate.			
20	The Pain threshold is lowered by anxiety or fatigue.			

Note: indicates correct response to item T= true, F= False, DK= don’t know

Part 3: **The Death Attitude Profile-Revised.**

Pleases read information in a questionnaire related to The Death Attitude Profile-Revised

(1) strongly disagree =SD
(2) disagree =D
(3) moderately disagree = MD
(4) Undecided = U
(5) moderately agree = MA
(6) Agree = A
(7) strongly agree = SA

No	content	Level of opinion						
		1	2	3	4	5	6	7
1	Death is no doubt a grim experience							
2	The prospects of my own death arouse anxiety in me.							
3	I avoid death thoughts at all costs							
4	I believe that I will be in heaven after I die.							
5	Death will bring an end to all my troubles.							
6	Death should be viewed as a natural, undeniable, and unavoidable event							
7	I am disturbed by the finality of death.							
8	Death is an entrance to a place of ultimate satisfaction.							
9	Death provides an escape from this terrible world.							
10	Whenever the thought of death enters my mind, I try to push it away							
11	Death is deliverance from pain and suffering.							
12	I always try not to think about death.							
13	I believe that heaven will be a much better place than this world							
14	Death is a natural aspect of life							
15	Death is a union with God and eternal bliss							
16	Death brings a promise of a new and glorious life							
17	I would neither fear death nor welcome it							
18	I have an intense fear of death							
19	I avoid thinking about death altogether							
20	The subject of life after death troubles me greatly.							
21	The fact that death will mean the end of everything as I know it frightens me.							
22	I look forward to a reunion with my loved ones after I die							
23	I view death as a relief from earthly suffering.							
24	Death is simply a part of the process of life.							

25	I see death as a passage to an eternal and blessed place							
26	I try to have nothing to do with the subject of death.							
27	Death offers a wonderful release of the soul							
28	One thing that gives me comfort in facing death is my belief in the afterlife							
29	I see death as a relief from the burden of this life.							
30	Death is neither good nor bad.							
31	I look forward to life after death							
32	The uncertainty of not knowing what happens after death worries me.							

Scoring Key for the Death Attitude Profile-Revised

Dimension Items

Fear of Death (7 items) 1,2,7,18,20,21,32

Death Avoidance (5 items) 3,10,12,19,26

Neutral Acceptance (5 items) 6,14,17,24,30

Approach Acceptance (10 items) 4,8,13,15,16,22,25,27,28,31

Escape Acceptance (5 items) 5,9,11,23,29.

Part 4: The Palliative Care Self-Efficacy Scale.

Explain for more information: Participants were asked to rate their perceived self-efficacy (capability) to successfully perform each palliative care task using a four-point gradation scale.

(1) need further basic instruction.

(2) confident to perform with close supervision/coaching.

(3) confident to perform with minimal consultation.

(4) confident to perform independently.

No	contents	Level of opinion			
		1	2	3	4
1	Answering patients questions about the dying process				
2	Supporting the patient or family member when they become upset				
3	Informing people of the support services available				
4	Discussing different environmental options (e.g. hospital, home, family)				
5	Discussing patient's wishes for after their death				
6	Answering queries about the effects of certain medications				
7	Reacting to reports of pain from the patient				
8	Reacting to and coping with terminal delirium				
9	Reacting to and coping with terminal dyspnea (breathlessness)				
10	Reacting to and coping with nausea/vomiting				

11	Reacting to and coping with reports of constipation				
12	Reacting to and coping with limited patient decision-making capacity				

Part 5: The Frommel Attitude Toward Care of Dying Patients Scale 30 items.

Explain for more information

(1) mean strongly disagree =SD
(2) mean disagree = D
(3) mean undecided = U
(4) mean Agree = A
(5) mean strongly agree = SA

No	contents	Level of opinion				
		1	2	3	4	5
1	Giving care to the dying person is a worthwhile experience.					
2	Death is not the worst thing that can happen to a person.					
3	I would be uncomfortable talking about impending death with the dying person					
4	Caring for the patient's family should continue throughout the period of grief and bereavement					
5	I would not want to care for a dying person.					
6	The non-family caregivers should not be the one to talk about death with the dying person					
7	The length of time required to give care to a dying person would frustrate me.					
8	I would be upset when the dying person I was caring for gave up hope of getting better.					
9	It is difficult to form a close relationship with the dying person.					
10	There are times when death is welcomed by the dying person					
11	When a patient asks, "Am I dying?" I think it is best to change the subject to something cheerful					
12	The family should be involved in the physical care of the dying person					
13	I would hope the person I'm caring for dies when I am not present.					
14	I am afraid to become friends with a dying person.					
15	I would feel like running away when the person actually died					
16	Families need emotional support to accept the behavior					

	changes of the dying person					
17	As a patient nears death, the non-family caregiver should withdraw from his or her involvement with the patient					
18	Families should be concerned about helping their dying member make the best of his or her remaining life					
19	The dying person should not be allowed to make decisions about his or her physical care.					
20	Families should maintain as normal an environment as possible for their dying member.					
21	It is beneficial for the dying person to verbalize his or her feelings					
22	Care should extend to the family of the dying person					
23	Caregivers should permit dying persons to have flexible visiting schedules					
24	The dying person and his or her family should be the in-charge decision makers					
25	Addiction to pain relieving medication should not be a concern when dealing with a dying person.					
26	I would be uncomfortable if I entered the room of a terminally ill person and found him or her crying.					
27	Dying persons should be given honest answers about their condition.					
28	Educating families about death and dying is not a non-family caregiver's responsibility					
29	Family members who stay close to a dying person often interfere with the professional's job with the patient					
30	It is possible for non-family caregivers to help patients prepare for death.					

ເລກທີ:.....

ແບບສອບຖາມ

ຄວາມຮູ້, ທັດສະນະຄະຕິ ແລະປະສິດທິພາບຂອງຕົນເອງຕໍ່ກັບການດູແລແບບປະຄັບປະຄອງ ແລະ ໄລຍະສຸດທ້າຍຂອງຊີວິດຂອງບັນດານັກສຶກສາຫຼັກສູດຊັ້ນສູງພະຍາບານໃນສາທາລະນະລັດ ປະຊາທິປະໄຕປະຊາຊົນ.

I. ແບບສອບຖາມທີ່ໃຊ້ໃນການສຶກສານີ້ລວມມີ 05 ພາກສ່ວນປະກອບດ້ວຍ:

(a) ສ່ວນທີ 1: ແບບສອບຖາມປະຊາກອນ.

(b) ສ່ວນທີ 2: ແບບສອບຖາມການດູແລແບບປະຄັບປະຄອງສຳລັບພະຍາບານ 20 ລາຍການ.

(c) ສ່ວນທີ 3: ຂໍ້ມູນທັດສະນະຄະຕິການຕາຍສະບັບປັບປຸງ 32 ລາຍການ

(d) ສ່ວນທີ 4: ການປະເມີນປະສິດທິພາບຂອງຕົນເອງຕໍ່ການດູແລແບບປະຄັບປະຄອງ 12 ລາຍການ.

(e) ສ່ວນທີ 5: ການວັດແທກທັດສະນະຄະຕິຂອງ Frommel ຕໍ່ການດູແລຄົນເຈັບທີ່ເສຍຊີວິດ 30 ລາຍການ.

ສ່ວນທີ 1 : ຂໍ້ມູນສ່ວນຕົວ:

ຂໍ້ມູນທົ່ວໄປ: ກະລຸນາຕື່ມໃສ່ບ່ອນເປົ່າຫວ່າງ ແລະໃຊ້ເຄື່ອງໝາຍ ✓ ໃສ່ໃນ ☐ ດ້ວຍຄຳຕອບທີ່ຖືກຕ້ອງ.

1. ເພດ: ☐ ຊາຍ ☐ ຍິງ
2. ອາຍຸ: ☐ 19-20 ປີ ☐ 21-30 ປີ ☐ 31-40 ປີ ☐ 41-50 ປີ
3. ປະສົບການຝຶກຫັດ: ☐ 1-2 ປີ ☐ 3-4 ປີ ☐ 5-10 ປີ
4. ປີການສຶກສາ: ☐ ປີ 01 ☐ ປີ 02 ☐ ປີ 03
5. ສາສະໜາ: ☐ ພຸດ ☐ ຄຣິສ ☐ ຜີ ☐ ອື່ນໆ.....
6. ສັນຊາດ: ☐ ລາວ ☐ ອື່ນໆ .....
7. ສະຖານະພາບ: ☐ ໂສດ ☐ ແຕ່ງງານ ☐ ຢ່າຮ້າງ ☐ ຄົນອື່ນ .....
8. ສະຖາບັນການສຶກສາ :

☐ ໂຮງຮຽນພະຍາບານແຂວງຄຳມ່ວນ

☐ ໂຮງຮຽນພະຍາບານແຂວງອຸດົມໄຊ

☐ ໂຮງຮຽນພະຍາບານແຂວງຊຽງຂວາງ

☐ ໂຮງຮຽນພະຍາບານແຂວງວຽງຈັນ

☐ ວິທະຍາໄລວິທະນາສາດສຸຂະພາບ ແຂວງຈຳປາສັກ

☐ ວິທະຍາໄລວິທະນາສາດສຸຂະພາບ ແຂວງຫຼວງພະບາງ

ສ່ວນທີ2: ແບບສອບຖາມການດູແລແບບປະຄັບປະຄອງສຳລັບພະຍາບານ 20 ລາຍການ.

ໝາຍເຫດ: ສະແດງເຖິງການຕອບຖືກຕໍ່ຄຳຖາມ

1. T = True = ຖືກຕ້ອງ
2. F = False = ຜິດ
3. DK = Don't know = ບໍ່ຮູ້

ລ/ດ	ເນື້ອໃນ	ຖືກ	ຜິດ	ບໍ່ຮູ້
1	ການດູແລແບບປະຄັບປະຄອງແມ່ນເໝາະສົມສະເພາະໃນສະຖານະການທີ່ມີການສະແດງຂອງຮ່າງກາຍຫຼຸດລົງ ຫຼື ການເສື່ອມລົງ.			
2	ຢາຝິ່ນ (Morphine) ແມ່ນມາດຕະຖານທີ່ໃຊ້ເພື່ອປຽບທຽບກັບປະສິດທິຜົນແກ້ປວດຂອງຢາສະນິດອື່ນໆ.			
3	ຂອບເຂດ ຫຼື ຂັ້ນຂອງພະຍາດກຳນົດວິທີການປິ່ນປົວຂອງອາ ການເຈັບປວດ			
4	ການປິ່ນປົວແບບປະຄັບປະຄອງແມ່ນມີຄວາມສຳຄັນໃນການຈັດ ການກັບຄວາມເຈັບປວດ			
5	ເປັນສິ່ງສຳຄັນຫຼາຍສຳລັບສະມາຊິກໃນຄອບຄົວທີ່ຈະຕ້ອງຢູ່ໃກ້ຊິດ ຂ້າງຕຽງຄົນເຈັບຈົນກວ່າຈະເສຍຊີວິດ.			
6	ໃນລະຫວ່າງວັນສຸດທ້າຍຂອງຊີວິດ, ອາການງ້ວງນອນທີ່ກ່ຽວ ຂ້ອງ ກັບຄວາມບໍ່ສົມດຸນຂອງເກືອແຮ່ໃນຮ່າງກາຍ (electrolyte) ອາດ ຫຼຸດຄວາມຈຳເປັນໃນການລະງັບປະສາດ.			
7	ການຕິດຢາເປັນບັນຫາສຳຄັນເມື່ອໃຊ້ຢາ morphine ໃນໄລຍະ ຍາວເພື່ອຫຼຸດຜ່ອນຄວາມເຈັບປວດ.			
8	ບຸກຄົນຜູ້ທີ່ກິນຢາແກ້ປວດ (opioids) ຄວນປະຕິບັດຕາມລະບົບ ການເຮັດວຽກຂອງລຳໄສ້.			
9	ການດູແລແບບປະຄັບປະຄອງຕ້ອງອາໃສ່ຄວາມໝັ້ນຄົງທາງອາລົມ.			
10	ໃນໄລຍະຂັ້ນສຸດທ້າຍຂອງຄວາມເຈັບປ່ວຍ, ຢາທີ່ສາມາດຊ່ວຍຫຼຸດ ອັດຕາການຫາຍໃຈແມ່ນມີຄວາມເໝາະສົມສຳຫຼັບການຮັກ ສາອາ ການຫາຍໃຈລຳບາກຢ່າງຮຸນແຮງ.			
11	ໂດຍທົ່ວໄປແລ້ວເພດຊາຍແກ້ໄຂຄວາມໂສກເສົ້າຂອງເຂົາເຈົ້າໄດ້ໄວ ກວ່າເພດຍິງ.			
12	ທິດສະດີປັດຊະຍາຂອງການດູແລແບບປະຄັບປະຄອງແມ່ນສາ ມາດ ເຂົ້າກັນໄດ້ກັບການປິ່ນປົວແບບຖືກບຸກລຸກທາງດ້ານຮ່າງ ກາຍ.			

13	ການໃຊ້ຢາປອມແມ່ນເໝາະສົມໃນການປິ່ນປົວອາການເຈັບປວດ ບາງປະເພດ.			
14	ໃນປະລິມານທີ່ສູງຂອງໂຄເດອິນ (codeine) ເຮັດໃຫ້ເກີດອາການ ປຸ້ນທ້ອງປວດຮາກ ແລະ ຮາກຫຼາຍກວ່າຢາ (morphine).			
15	ຄວາມທຸກທໍລະມານ ແລະ ຄວາມເຈັບປວດທາງດ້ານຮ່າງກາຍແມ່ນ ມີຄວາມໝາຍຄືກັນ.			
16	ຢາ Demerol ບໍ່ແມ່ນຢາແກ້ປວດທີ່ມີປະສິດທິພາບໃນການຄວບ ຄຸມອາການເຈັບປວດແບບຊໍາເຮື້ອ.			
17	ການສະສົມຄວາມສູນເສຍເຮັດໃຫ້ມີຄວາມເບື່ອໜ່າຍທີ່ຫຼີກລ່ຽງບໍ່ ໄດ້ສໍາລັບຜູ້ທີ່ຊອກຫາວຽກເຮັດໃນການດູແລແບບປະຄັບປະ ຄອງ.			
18	ການສະແດງອາການເຈັບປວດຊໍາເຮື້ອແມ່ນແຕກຕ່າງຈາກອາ ການ ເຈັບປວດກະທັນຫັນ.			
19	ການສູນເສຍຄວາມສໍາ ພັນທີ່ຫ່າງໄກ ຫຼື ຄວາມຂັດແຍ້ງນັ້ນແກ້ໄຂ ໄດ້ງ່າຍກວ່າການສູນເສຍຄວາມສໍາພັນທີ່ໃກ້ຊິດ ຫຼື ສະໜິດສະໜົມ.			
20	ຄວາມເຈັບປວດຈະຫຼຸດລົງດ້ວຍຄວາມວິຕົກກັງວົນ ຫຼື ຄວາມອິດ ເມື່ອຍ.			

ສ່ວນທີ 3 : ການປັບປຸງທັດສະນະຄະຕິຕໍ່ຮູບແບບຄວາມຕາຍ

ກະລຸນາອ່ານຂໍ້ມູນຢູ່ໃນແບບສອບຖາມທີ່ກ່ຽວຂ້ອງກັບໂປຣໄຟລ Death ທັດສະນະຄະຕິການ ຕາຍ-ທົບທວນຄືນ

(1) ໝາຍຄວາມວ່າ ບໍ່ເຫັນດີຫຼາຍທີ່ສຸດ.

(2) ຫມາຍຄວາມວ່າ ບໍ່ເຫັນດີ.

(3) ໝາຍຄວາມວ່າ ບໍ່ແນ່ໃຈ.

(4) ໝາຍຄວາມວ່າ ເຫັນດີ.

(5) ໝາຍຄວາມວ່າ ເຫັນດີຫຼາຍທີ່ສຸດ.

ລ/ດ	**ເນື້ອໃນ**	ລະດັບຄວາມຄິດເຫັນ				
		1	2	3	4	5
1	ແມ່ນອນວ່າຄວາມຕາຍເປັນປະສົບການອັນຮ້າຍແຮງທີ່ໜ້າຢ້ານກົວ					
2	ຄວາມຫວັງຂອງການຕາຍຂອງຂ້ອຍເອງເຮັດໃຫ້ເກີດຄວາມກັງວົນຢູ່ໃນຕົວຂ້ອຍ.					
3	ຂ້ອຍຫຼີກລ່ຽງຄວາມຄິດກ່ຽວກັບຄວາມຕາຍໃນທຸກວິທີທາງ					
4	ຂ້າພະເຈົ້າເຊື່ອວ່າຂ້າພະເຈົ້າຈະຢູ່ໃນສະຫວັນຫຼັງຈາກທີ່ຂ້າພະເຈົ້າຕາຍ.					
5	ຄວາມຕາຍຈະເຮັດໃຫ້ບັນຫາທັງໝົດຂອງຂ້ອຍໝົດໄປ.					
6	ຄວາມຕາຍຄວນຖືວ່າເປັນເຫດການທຳມະຊາດ, ປະຕິເສດບໍ່ໄດ້ ແລະຫຼີກລ່ຽງບໍ່ໄດ້					
7	ຂ້າພະເຈົ້າຖືກລົບກວນໃນໄລຍະສຸດທ້າຍຂອງຄວາມຕາຍ.					
8	ຄວາມຕາຍເປັນເສັ້ນທາງເຂົ້າສູ່ສະຖານທີ່ແຫ່ງຄວາມພຶງພໍໃຈສູງສຸດ.					
9	ຄວາມຕາຍຊ່ວຍໃຫ້ຫຼີກໜີຈາກໂລກອັນໂຫດຮ້າຍນີ້.					
10	ເມື່ອໃດກໍ່ຕາມທີ່ຄວາມຄິດເລື່ອງຄວາມຕາຍເຂົ້າມາໃນຈິດໃຈຂອງຂ້ອຍ, ຂ້ອຍພະຍາຍາມຍູ້ມັນອອກໄປ					
11	ຄວາມຕາຍຄືການປົດປ່ອຍຈາກຄວາມເຈັບປວດ ແລະຄວາມທຸກທໍລະມານ.					
12	ຂ້າພະເຈົ້າພະຍາຍາມສະໝໍ່ທີ່ຈະບໍ່ຄິດກ່ຽວກັບຄວາມຕາຍ.					
13	ຂ້າພະເຈົ້າເຊື່ອວ່າສະຫວັນຈະເປັນບ່ອນທີ່ໜ້າຢູ່ກວ່າໂລກນີ້					
14	ຄວາມຕາຍເປັນລັກສະນະທຳມະຊາດຂອງຊີວິດ					
15	ການເສຍຊີວິດຄືການຮ່ວມກັບພຣະພຸດທະເຈົ້າ ແລະຄວາມ ສຸກນິລັນດອນ.					
16	ຄວາມຕາຍຈະນຳມາຊຶ່ງຊີວິດໃໝ່ທີ່ຮຸ່ງເຮືອງ					
17	ຂ້າພະເຈົ້າຈະບໍ່ຢ້ານຄວາມຕາຍ ຫຼື ບໍ່ຍິນດີຕ້ອນຮັບມັນ					
18	ຂ້າພະເຈົ້າມີຄວາມຢ້ານກົວຄວາມຕາຍຫຼາຍ					
19	ຂ້າພະເຈົ້າຫຼີກລ່ຽງຄວາມຄິດກ່ຽວກັບຄວາມຕາຍທັງໝົດ					
20	ເລື່ອງຂອງຊີວິດຫຼັງຄວາມຕາຍເຮັດໃຫ້ຂ້ອຍລຳບາກໃຈຫຼາຍ.					
21	ຄວາມຈິງທີ່ວ່າຄວາມຕາຍຈະໝາຍເຖິງຈຸດຈົບຂອງທຸກຢ່າງດັ່ງທີ່ຂ້ອຍຮູ້ມັນເຮັດໃຫ້ຂ້ອຍຢ້ານ.					

22	ຂ້າພະເຈົ້າຫວັງວ່າຈະໄດ້ພົບກັບຄົນທີ່ຂ້ອຍຮັກຫຼັງຈາກຂ້ອຍຕາຍ					
23	ຂ້າພະເຈົ້າຖືວ່າຄວາມຕາຍເປັນການບັນເທົາຈາກຄວາມທຸກທໍ ລະ ມານທາງໂລກນີ້.					
24	ຄວາມຕາຍເປັນພຽງສ່ວນໜຶ່ງຂອງຂະບວນການຊີວິດ.					
25	ຂ້າພະເຈົ້າເຫັນຄວາມຕາຍເປັນທາງຜ່ານໄປສູ່ສະຖານທີ່ນິລັນ ດອນ ແລະ ມີຄວາມສຸກ					
26	ຂ້າພະເຈົ້າພະຍາຍາມທີ່ຈະບໍ່ກ່ຽວຂ້ອງກັບເລື່ອງຂອງຄວາມຕາຍ.					
27	ຄວາມຕາຍເປັນການປ່ອຍຈິດວິນຍານທີ່ໜ້າອັດສະຈັນ					
28	ສິ່ງໜຶ່ງທີ່ເຮັດໃຫ້ຂ້ອຍສະບາຍໃຈໃນການປະເຊີນໜ້າກັບຄວາມ ຕາຍແມ່ນຄວາມເຊື່ອໃນຊີວິດຫຼັງຄວາມຕາຍ					
29	ຂ້າພະເຈົ້າເຫັນວ່າຄວາມຕາຍຈະເປັນການຊ່ວຍແກ້ບັນຫາຂອງຊີວິດ ນີ້.					
30	ຄວາມຕາຍບໍ່ແມ່ນທັງສິ່ງທີ່ດີ ແລະ ສິ່ງທີ່ບໍ່ດີ					
31	ຂ້າພະເຈົ້າລໍຖ້າຊີວິດຫຼັງຈາກຄວາມຕາຍ					
32	ຄວາມບໍ່ແນ່ນອນຂອງການບໍ່ຮູ້ວ່າຈະເກີດຫຍັງຂຶ້ນຫຼັງຈາກຄວາມ ຕາຍຂອງຂ້ອຍ					

ຄະແນນສຳຫຼັບ ທັດສະນະຄະຕິການຕາຍ-ທິບທອນລາຍການມິຕິ

ການຢ້ານຄວາມຕາຍ (7 ລາຍການ) 1,2,7,18,20,21,32

ການຫຼົບຫຼີກຄວາມຕາຍ (5 ລາຍການ) 3,10,12,19,26

ການຍອມຮັບເປັນກາງ (5 ລາຍການ) 6,14,17,24,30

ແນວທາງການຍອມຮັບ (10 ລາຍການ) 4,8,13,15,16,22,25,27,28,31

ຫຼີກໜີການຍອມຮັບ (5 ລາຍການ) 5,9,11,23,29.

ສ່ວນທີ 4: ການປະເມີນປະສິດທິພາບຕົນເອງຂອງການດູແລແບບປະຄັບປະຄອງ.

ອະທິບາຍສຳລັບຂໍ້ມູນເພີ່ມເຕີມ: ຂໍໃຫ້ຜູ້ເຂົ້າຮ່ວມປະເມີນຄວາມສາມາດຂອງຕົນເອງໃນການດຳ ເນີນການດູແລແບບປະຄັບປະຄອງແຕ່ລະຄັ້ງໃຫ້ປະສົບຄວາມສຳເລັດໂດຍໃຊ້ມາດຕາສ່ວນການ ຄິດໄລ່ອັດລະດັບ 04 ຈຸດ .

(1) ຕ້ອງການຄຳແນະນຳພື້ນຖານເພີ່ມເຕີມ.

(2) ເຊື່ອໝັ້ນໃນການປະຕິບັດງານດ້ວຍການດູແລ/ການຝຶກສອນຢ່າງໃກ້ຊິດ.

(3) ໝັ້ນໃຈໃນການດຳເນີນການດ້ວຍການປຶກສາຫາລືໜ້ອຍທີ່ສຸດ.

(4) ເຊື່ອໝັ້ນໃນການດຳເນີນການປະຕິບັດຢ່າງເປັນອິດສະຫຼະ.

ລ/ດ	ເນື້ອໃນ	ລະດັບຄວາມຄິດເຫັນ			
		1	2	3	4
1	ການຕອບຄຳຖາມຄົນເຈັບກ່ຽວກັບຂະບວນການຕາຍ				
2	ຊ່ວຍເຫຼືອຄົນເຈັບ ຫຼື ສະມາຊິກໃນຄອບຄົວເມື່ອຮູ້ສຶກບໍ່ສະບາຍໃຈ				
3	ການແຈ້ງໃຫ້ຜູ້ຄົນຮູ້ກ່ຽວກັບການບໍລິການຊ່ວຍເຫຼືອທີ່ມີຢູ່				
4	ອະທິບາຍທາງເລືອກດ້ານສິ່ງແວດລ້ອມທີ່ແຕກຕ່າງກັນ(ເຊັ່ນ: ໂຮງໝໍ, ເຮືອນ, ຄອບຄົວ)				
5	ປຶກສາຫາລືກ່ຽວຄວາມປາດຖະໜາຂອງຄົນເຈັບຫຼັງຄວາມຕາຍ				
6	ຕອບຄຳຖາມກ່ຽວກັບຜົນກະທົບຂອງຢາບາງຊະນິດ				
7	ການຕອບສະໜອງຕໍ່ການລາຍງານຄວາມເຈັບປວດຈາກຄົນເຈັບ				
8	ຕອບສະໜອງ ແລະການຮັບມືກັບອາການເພ້ີ່ປ່ອງ				
9	ການຕອບສະໜອງ ແລະ ຮັບມືກັບອາການຫາຍໃຈລຳບາກໄລຍະສຸດທ້າຍ (ຫາຍໃຈບໍ່ອອກ)				
10	ການຕອບສະໜອງ ແລະຮັບມືກັບອາການປຸ້ນທ້ອງ, ປວດຮາກ ແລະ ຮາກ				
11	ການຕອບສະໜອງ ແລະຮັບມືກັບລາຍງານຂອງອາການທ້ອງຜູກ				
12	ການຕອບສະໜອງ ແລະການຮັບມືກັບຄວາມສາມາດໃນການຕັດສິນໃຈຂອງຄົນເຈັບທີ່ຈຳກັດ.				

ສ່ວນທີ 5: ການວັດແທກທັດສະນະຄະຕິຂອງ Frommel ຕໍ່ການດູແລຄົນເຈັບທີ່ເສຍຊີວິດ 30 ລາຍການ.

ອະທິບາຍສຳລັບຂໍ້ມູນເພີ່ມເຕີມ

(1) ໝາຍຄວາມວ່າບໍ່ເຫັນດີຢ່າງຍິ່ງ

(2) ໝາຍຄວາມວ່າບໍ່ເຫັນດີ

(3) ໝາຍຄວາມວ່າບໍ່ແນ່ໃຈ

(4) ໝາຍຄວາມວ່າເຫັນດີ

(5) ໝາຍຄວາມວ່າເຫັນດີຫຼາຍ

ລ/ດ	ເນື້ອໃນ	ລະດັບຄວາມຄິດເຫັນ				
		1	2	3	4	5
1	ການໃຫ້ການດູແລຄົນເຈັບທີ່ໃກ້ຕາຍເປັນປະສົບການທີ່ຄຸ້ມຄ່າ.					
2	ຄວາມຕາຍບໍ່ແມ່ນສິ່ງທີ່ຮ້າຍແຮງທີ່ສຸດທີ່ສາມາດເກີດຂຶ້ນກັບຄົນຜູ້ ໜຶ່ງ.					
3	ຂ້ອຍບໍ່ສະບາຍໃຈທີ່ຈະເວົ້າກ່ຽວກັບຄວາມຕາຍທີ່ກຳລັງຈະເກີດຂຶ້ນກັບຄົນທີ່ກຳລັງຈະຕາຍ.					
4	ການດູແລຄອບຄົວຂອງຄົນເຈັບຄວນດຳເນີນການຕໍ່ໄປຕະຫຼອດຊ່ວງເວລາຂອງຄວາມໂສກເສົ້າ ແລະການສູນເສຍ.					
5	ຂ້ອຍບໍ່ຕ້ອງການເບິ່ງແຍງຄົນທີ່ກຳລັງຈະຕາຍ.					
6	ຜູ້ດູແລທີ່ບໍ່ແມ່ນຄອບຄົວບໍ່ຄວນເປັນຜູ້ເວົ້າກ່ຽວກັບເລື່ອງຄວາມຕາຍກັບຄົນທີ່ກຳລັງຈະເສຍຊີວິດ.					
7	ໄລຍະເວລາທີ່ຕ້ອງໃຊ້ໃນການດູແລຄົນທີ່ກຳລັງຈະຕາຍຈະເຮັດໃຫ້ຂ້ອຍງຸດງິດ.					
8	ຂ້ອຍຈະບໍ່ພໍໃຈເມື່ອຄົນທີ່ກຳລັງຈະຕາຍທີ່ຂ້ອຍໄດ້ດູແລໝົດຄວາມຫວັງທີ່ຈະດີຂຶ້ນ.					
9	ເປັນການຍາກທີ່ຈະສ້າງຄວາມສຳພັນທີ່ໃກ້ຊິດກັບຄົນທີ່ກຳລັງຈະຕາຍ.					
10	ມີຫຼາຍຄັ້ງທີ່ຄວາມຕາຍໄດ້ຮັບການຕ້ອນຮັບຈາກຜູ້ຕາຍ					
11	ເມື່ອຄົນເຈັບຖາມວ່າ, "ຂ້ອຍກຳລັງຈະຕາຍບໍ່?" ຂ້ອຍຄິດວ່າມັນດີທີ່ສຸດທີ່ຈະປ່ຽນເລື່ອງສົນທະນາໃຫ້ເປັນເລື່ອງທີ່ເຮັດໃຫ້ເບີກບານມ່ວນຊື່ນ.					
12	ຄອບຄົວຄວນມີສ່ວນຮ່ວມໃນການດູແລຮ່າງກາຍຂອງຜູ້ຕາຍ.					
13	ຂ້ອຍຫວັງວ່າຄົນທີ່ຂ້ອຍດູແລຈະເສຍຊີວິດເມື່ອຂ້ອຍບໍ່ຢູ່ໃນສະຖານທີ່ເຮັດວຽກ.					
14	ຂ້ອຍຢ້ານທີ່ຈະເປັນເພື່ອນກັບຄົນທີ່ກຳລັງຈະຕາຍ.					
15	ຂ້ອຍຮູ້ສຶກທີ່ຈະຫຼີກໜີເມື່ອເຫັນຄົນເສຍຊີວິດຕົວຈິງ.					
16	ຄອບຄົວຕ້ອງການການສະໜັບສະໜູນທາງດ້ານອາລົມເພື່ອຍອມຮັບການປ່ຽນແປງພຶດຕິກຳຂອງຄົນທີ່ກຳລັງຈະຕາຍ.					
17	ໃນຂະນະທີ່ຄົນເຈັບໃກ້ຈະຕາຍ, ຜູ້ດູແລທີ່ບໍ່ແມ່ນຄອບ ຄົວ ຄວນຖອນຕົວອອກຈາກການມີສ່ວນຮ່ວມກັບຄົນເຈັບ.					

18	ຄອບຄົວຄອນກັງວົນກ່ຽວກັບການຊ່ວຍເຫຼືອສະມາຊິກທີ່ກຳລັງຈະເສຍຊີວິດໃຫ້ໃຊ້ຊີວິດທີ່ເຫຼືອຢູ່ໃຫ້ດີທີ່ສຸດ					
19	ບຸກຄົນທີ່ກຳລັງຈະເສຍຊີວິດບໍ່ຄອນໄດ້ຮັບອະນຸຍາດໃຫ້ຕັດສິນໃຈກ່ຽວກັບການດູແລຮ່າງກາຍຂອງຕົນເອງ.					
20	ຄອບຄົວຄອນຮັກສາສະພາບແວດລ້ອມໃຫ້ເປັນປົກກະ ຕິທີ່ສຸດ ສຳລັບສະມາຊິກທີ່ກຳລັງຈະຕາຍ.					
21	ເປັນປະໂຫຍດສຳລັບຄົນທີ່ກຳລັງຈະຕາຍເພື່ອໃຫ້ເວົ້າຄວາມຮູ້ສຶກຂອງລາວ.					
22	ການດູແລຄອນຂະຫຍາຍຄອບຄຸມໄປເຖິງຄອບຄົວຂອງຜູ້ຕາຍ.					
23	ຜູ້ດູແລຄອນອະນຸຍາດໃຫ້ຄົນທີ່ກຳລັງຈະເສຍຊີວິດມີຕາຕະລາງການເຂົ້າຢ້ຽມທີ່ຍືນຢຸ່ນ ຫຼື ນະໂຍບາຍໄດ້.					
24	ບຸກຄົນທີ່ກຳລັງຈະເສຍຊີວິດ ແລະຄອບຄົວຄອນເປັນຜູ້ມີອຳນາດໃນການຕັດສິນໃຈ.					
25	ການຕິດໄຊ້ຢາແກ້ປວດບໍ່ຄອນກັງວົນເມື່ອຕ້ອງຮັບມືກັບຄົນໃກ້ຕາຍ.					
26	ຂ້ອຍຈະບໍ່ສະບາຍໃຈຖ້າຂ້ອຍເຂົ້າໄປໃນຫ້ອງຂອງຄົນເຈັບໄລຍະສຸດທ້າຍ ແລະພົບວ່າລາວຮ້ອງໃຫ້.					
27	ຄົນທີ່ກຳລັງຈະຕາຍຄອນໄດ້ຮັບຄຳຕອບທີ່ກົງໄປກົງມາກ່ຽວກັບສະພາບຂອງພວກເຂົາ.					
28	ການໃຫ້ຄວາມຮູ້ແກ່ຄອບຄົວກ່ຽວກັບຄວາມຕາຍ ແລະການຕາຍບໍ່ແມ່ນຄວາມຮັບຜິດຊອບຂອງຜູ້ດູແລທີ່ບໍ່ແມ່ນຄອບຄົວ.					
29	ສະມາຊິກໃນຄອບຄົວຜູ້ທີ່ຢູ່ໃກ້ຊິດກັບຄົນເຈັບທີ່ກຳລັງຈະເສຍຊີວິດມັກຈະລົບກວນການເຮັດວຽກຂອງຜູ້ຊ່ຽວ ຊານກ່ຽວກັບຄົນເຈັບ.					
30	ຜູ້ດູແລທີ່ບໍ່ແມ່ນຄອບຄົວສາມາດຊ່ວຍໃຫ້ຄົນເຈັບຕຽມຄວາມພ້ອມສຳຫຼັບຄວາມຕາຍໄດ້.					

Lao People's Democratic Republic
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Ministry of Health
National Ethics Committee
for Health Research (NECHR)

No 010 /NECHR
Vientiane Capital 14 / 01 / 2022

Approval Notice

Mr. Khamsone Naovalad
Email: khamsonesone2@gmail.com

RE: Ethical Approval for Health Research

Title: "Nursing student's knowledge, self-efficacy of palliative care and attitude toward end-of-life nursing in Laos" (Submission ID: 2021.49)

Dear Mr. Khamsone Naovalad,

The National Ethics Committee for Health Research of the Lao People's Democratic Republic have reviewed and approved your research.

Please note the following information about your approved research protocol:

Approval period		January 2022 – January 2023	
Approved Subject Enrollment		269	
Study Site	Khammuan, Oudomxai, Xiengkuang, Champasak, Luangprabang, and Vientiane provinces.		
Sponsor	Korea foundation for international health care (Kofih)	**Budget**	3,000,000 LAK
Implementing Panel/Project Investigator		Mr. Khamsone Naovalad	
Please note that the Ethics Committee reserves the right to ask for further questions, seek additional or monitor the conduct of your research and consent process.			
Principle Investigator is required to notify the Secretary of the National Ethic Committee for Health Research	• Any significant change to the project and the reason for that change, including an indication of ethical implications (if any); • Serious adverse effects on participants and the action taken to address those effects; • Any other unforeseen events or unexpected developments that merit notification; • The inability of the Principal Investigator to continue in that role, or any other change in research personnel involved in the project; • Any other unforeseen events or unexpected developments that merit notification; • The inability of the Principal Investigator to continue in that role, or any other change in research personnel involved in the project; • Any expiry of the insurance coverage provided with respect to sponsored clinical trials and proof of re-insurance; • A delay of more than 12 months in the commencement of the project; and, • Termination or closure of the project.		

Additionally, the Principal Investigator is required to submit a progress report on the anniversary of approval and on completion of the project.

President of NECHR

Dr. Sengchanh KOUNNAVONG

permission to use the questionnaire from the original author

Request for Using Questionnaire: PCQN-Korean version

Date of the request:

User: Khamsone NAOVALAD (National Cancer Center Graduate School of Cancer Science and Policy, Republic of Korea)

e-mail: khamsonesone2@gmail.com

Dear NAOVALAD,

I am delighted you have found the Korean version of Palliative Care Quiz for Nursing (PCQN) a useful instrument in your research. On behalf of research team, I was permitted to translate it into Korean and to use this instrument from the original author, Margaret Ross. You have my permission to translate and implement the PCQN-Korean version for your purposes. I wish you luck with your research. Please do not hesitate to contact me again if you have further questions.

All the best.

Sanghee Kim, PhD, RN

Associate Dean of Academic Affairs,

Associate Professor,

Yonsei University College of Nursing

e-mail: sangheekim@yuhs.ac

Updates Messages Requests

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Naovalad Khamsone 17 hours ago

Dear, Paul T. P. Wong,
My name is khamsone NAOVALAD, I'm a student (master's degree) in oncology nursing course at Department of Cancer Control and Population Health, National Cancer center Graduate school of cancer science and policy (NCC-GCSP),Republic of Korea.
Now I'm doing research for my thesis graduation; my topic is "Nursing student's knowledge, self-efficacy of palliative care and attitude toward end-of-life nursing in Laos" that I would like to use The Death Attitude Profile-Revised 32 item (DAP-R-C) questionnaire in my thesis. I would like to use the English version.
Therefore, I sent this email to you to request permission to use this questionnaire.
Best regards,
Khamsone NAOVALAD

Paul T. P. Wong to you 35 minutes ago

Yes, I am pleased to grant you my permission.

Khamsone Sone 11:46 (10 hours ago)

Dear Professor Yenna Salamonson,Good evening professor, my name is Noavalad Khamsone, Now I have studied master course (oncology nursing) in National cancer cen

Yenna Salamonson 11:49 (10 hours ago)

to me

Dear Naovalad,

Of course you can reuse the instrument. It's been a while since we published this, so I'm not sure if I have the original tool, but if all the information is in the paper, feel free to use it. Best!

Kind Regards,

Yenna

Yenna Salamonson RN, BSc, CCU Cert, GradDipNEd, MA(EdkWork), PhD

Professor | Director of Academic Workforce, Campbelltown

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I believe in working flexibly and I send messages to suit my circumstances. I don't expect that you will read, respond to, or action if outside of regular working hours.

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The effects of death education on nurses' attitudes toward caring for terminally ill persons and their families

Author: Katherine H. Murray Frommelt

Publication: American Journal of Hospice and Palliative Medicine

Publisher: SAGE Publications

Date: 09/01/1991

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