ORIGINAL ARTICLE

Attendance at end-of-life care seminars and related factors among home visiting nurses

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Abstract

Aims: The aim of this study was to identify the factors associated with the opportunities that home visiting nurses attended seminars about end-of-life care.

Method: This was a cross-sectional correlation study. Data were gathered from 343 home visiting nurses working in 62 agencies across Chiba prefecture in eastern Japan. The authors asked participants: (i) questions on socio-demographic data; (ii) questions on opportunities for attending end-of-life care seminars; and (iii) questions on agency characteristics. Opportunities for attending end-of-life care seminars were classified into two categories as either having an opportunity to attend end-of-life care seminars "0 times" or "once or more". Multivariate logistic regression analysis was performed to identify the relationship between attendance at end-of-life care seminars and related socio-demographic and agency characteristics.

Results: Data from 224 home visiting nurses working in 53 agencies were included in the analysis. Overall, 66 nurses (29.5%) had no opportunity to attend end-of-life care seminars. Multivariate logistic regression analysis showed that autonomy in providing end-of-life care (OR=2.82, 95% CI: 1.07–7.40) was associated with attendance at end-of-life care seminars.

Conclusion: Nursing managers should provide autonomy to staff in order to ensure quality of end-of-life care among nursing staff.

Key words

Autonomy in providing care, End-of-life care, Home visiting nurses, Seminar attendance

1 Introduction

Interest in home care has been increasing, especially among countries that have a rapidly aging society [1-3]. In 2000, the Japanese government established the public Long-Term Care Insurance system for the elderly to ensure independence and effective home care. From that time, the number of people who need home nursing care has been gradually increasing, and those aged 65 years and over are predicted to constitute 31.9% of the population by 2030, from 21.5% in 2007 [4]. Since the average length of a hospital stay has become shorter and the lifespan of a patient in the final stages of illness has become

longer, the clients of home visiting nursing have shifted from preventive care for conditions related to being bedridden to severe chronic disease or end-of-life care.

Previous studies showed that home visiting nursing services frequently provide care for people who require a severe care level and need medical treatment [5, 6]. Home visiting nurses have a central role in the provision of palliative care in the home [7]; they especially need an opportunity to learn about end-of-life care, as well as dementia care and respiratory care [8]. To better prepare nurses to care for dying patients and their families, end-of-life care seminars and educational programs should be offered as professional training in the practice of home visiting nursing in order to provide the knowledge and skills needed to assist and effectively communicate with patients and families [9].

However, home visiting nurses in practice reported that they were too busy to attend seminars because of the rapidly increasing demands of home care services. Their job descriptions include not only home visits, but also coordination with other professionals and indirect care tasks, such as paperwork and the completionof forms [10, 11]. Coordination with other professionals is a time-consuming task, since a home care team consists of multiple professionals from different agencies (i.e., clinics, care management offices, pharmacies, and home-helping services) for each patient after home-vists. The time for such indirect care tasks cannot be given to nurses by their agencies; therefore, nurses have difficulty attending seminars held at night time. Even when nurses indicate their desire to attend seminars, they do not have enough time to attend them.

Furthermore, there are fewer professional learning resources among home visiting nurses [12] than among other institutional nurses [13]. The Japan Visiting Nursing Association (2008) reported only 5% of agencies had some kind of educational program for new graduate nurses. This is a vicious cycle in that new graduate nurses seldom select home care agencies when starting their nursing careers, and thus, home visiting nursing agencies fail to hire those who have received recent education about home visiting nursing and end-of-life care in nursing schools and universities.

Previous studies showed that factors which inhibit attendance at end-of-life care seminars included inadequate support from the agency and geographical inaccessibility in rural area [8, 14, 15]. In the case of end-of-life care, personal experience and socio-demographic characteristics—such as experience in caring for terminally ill patients, employment status, and job status—directly relate to the amount of support that nurses receive from their agencies and their degree of commitment to caring for patients and their families. Previous studies have mainly focused on the learning needs of home visiting nurses [8]. These findings show only descriptive data and have several limitations. For example, various agency characteristics were not considered in the analyses and they focused on a subjective indicator, such as theneed for learning.

This study aimed to comprehensively analyze the relationship between attendance at end-of-life care seminars as an objective measurement and its related factors by including socio-demographic and agency characteristics.

2 Method

2.1 Study design

This study was conducted based on data from home visiting nurses working in agencies across Chiba prefecture in eastern Japan.

In May 2012, a search was conducted for home visiting nursing agencies on the Japanese database known as the Welfare and Medical services NETwork system [16]. Through this search, contact information was collected on 211 home visit nursing agencies in Chiba prefecture. In June 2012, 62 agencies (29.4% of the total contacted) agreed to participate and provided information on the number of nurses they employed.

Data was collected from July to August 2012. Anonymous self-administered questionnaires, of which there were two types, were sent to each agency. All nurses, including nursing managers, completed Questionnaire A, which collected information on socio-demographic characteristicsand experiences of caring for dying patients. Questionnaire B was applicable to only nursing managers and asked about agency characteristics. The managers collected the sealed questionnaires and returned them to the author. The questionnaire package included a $1 gift certificate for a sticky note.

2.2 Instruments

Questionnaire A and Questionnaire B consisted of three domains. All variables were selected from literature review [8, 10-12, 14, 15]. And also, the authors conducted interviews of seven home visiting managers, supervision of two researchers, and the experience of pretest by home visiting nursing manager who has managed home palliative care project.

2.2.1 Socio-demographic data

Sociodemographic data included age, sex, educational background (two-year vocational college, junior college, bachelor's degree, master's degree, or doctorate), years of nursing experience, years of home visit nursing experience, years of work experience in the current agency, employment status (full-time or part-time), job status, marital status, and experience rearing a preschool child. Whether they had experience caring for terminally ill patients was also asked.

2.2.2 Opportunity for attending end-of-life care seminars

Opportunity for attending end-of-life care seminars was measured with an original item, "How many times have you attended terminal care seminars in 2011?" The responses ranged from "0 times," "once," "twice," "about four times," "about six times," and "more than twelve times." In the data analysis, nurses were classified in two categories as having an opportunity to attend end-of-life care seminars "0 times" or "once or more." In this study, "end-of-life care seminars" included workshops, study meetings, and case briefing sessions about caring for terminally ill patients and their families.

2.2.3 Agency characteristics

Agency characteristics consisted of the area in which the agency was located (urban: over 3000 people per km^2, or rural: less than 3000 people per km^2), the number of home visit nursing staff, frequency of visits during July 2011, the total number of patients and the number of dying patients cared for by the agencies in 2011, the diseases of the terminally ill patients, the ratio of at-home deaths in 2011, the average service term for providing end-of-life care, the agencies' philosophies concerning provision of end-of-life care, seminar information for staff, autonomy in providing terminal care, and scheduling support for attending seminars. A sample item is "How have you been given autonomy to make decisions about providing terminal care?" The response categories for all items ranged from 1 (strongly disagree) to 5 (strongly agree).

Additionally, responses to questions in Questionnaire B were provided by a nursing manager in each agency. These data were distributed to each nurse in the same agency.

2.3 Statistical analysis

Descriptive statistics were used to describe the characteristics of the participants and the agencies. The data were analyzed using the chi-square test, the unpaired t-test, and multivariate logistic regression analysis to investigate the relationship between the participants' and agencies' characteristics, and the opportunities for attending end-of-life care seminars. Variables with values of $p < 0.10$ were selected and entered into a multivariate logistic regression model via a forced entry procedure. The authors assumed that the proportion of nurses who would report a complete lack of opportunity to attend end-of-life care seminars was 25%, nearly 75 such nurses, and the number of independent variables were eleven. According to this assumption, we need at least 100 nurses who report a complete lack of opportunity to attend end-of-life care seminars. The criterion for statistical significance was set at $p < 0.05$. All statistical analyses were conducted with the Statistical Package for Social Sciences (SPSS Inc., Chicago, IL, USA) version 18.0.

2.4 Ethical approval

The surveys were implemented in accordance with the Ethical Guidelines for Epidemiological Research of the Ministry of Health, Labour, and Welfare of Japan. This study was approved by The Institutional Review Board of the University of Tokyo.

Table 1. Characteristics of the participants

Variables	Mean or n	(SD) (%)	Range
Age	45.4	(7.3)	(27.0—63.0)
Sex			
Male	28	(98.2%)	
Female	220	(1.8%)	
Educational background			
Nursing school	182	(81.3%)	
College or university	41	(18.2%)	
Years of nursing experience	19.6	(7.4)	(4.0—40.0)
Years of home visit nursing experience	7.5	(5.0)	(1.0—32.0)
Years of working in the current agency	6.5	(5.3)	(1.0—35.0)
Experience of working in palliative unit or hospice			
Yes	4	(1.8%)	
No	210	(93.8%)	
Employment status			
Full time	164	(73.2%)	
Part time	60	(26.8%)	
Job status			
Nursing manager	46	(20.5%)	
Senior staff member	14	(6.3%)	
Visiting staff	164	(73.2%)	
Marital status			
Married	181	(80.8%)	
Unmarried	22	(9.8%)	
Divorced or bereaved	21	(9.4%)	
Rearing preschool child			
Yes	53	(22.3%)	
No	170	(77.2%)	

Note. N=224. Missing data were not included.

3 Results

3.1 Recruitment

Out of an initial total of 343 nurses contacted, 304 responded to the questionnaire (88.6% response rate). To avoid confounding the results, 25 nurses whose job status was unclear and 55 nurses who had less than one year of experience

working in the current agency, were excluded. Finally, data from 224 nurses (65.3%) working in 53 agencies were included in the analysis.

Descriptive statistics are shown in Table 1. The mean age of the participants was 45.4 years (range, 27.0–63.0 years, SD = 7.3), and the mean of home visiting nursing experience was 7.49 years (SD = 4.9). Most participants worked full-time (73.2%).

Table 2 shows the characteristics of the participants' agencies. An almost equal number of agencies were located in urban and rural areas. The mean number of nursing staff was 5.8 (range, 3.0–16.0, SD = 2.7). Twenty-five agencies (47.2%) reported a high number of cancer patients among their terminally ill patients. Most of the agencies provided end-of-life care for less than six months.

Table 2. Characteristics of the agencies

Variables	Mean or n	(SD) (%)	Range
Location of agency			
Urban	25		
Rural	28		
Number of nursing staff	5.8	(2.7)	(3.0—16.0)
Number of total patients cared for in 2011	405.2	(599.4)	(14.0—3295.0)
Number of dying patients cared for in 2011	22.8	(12.8)	(3.0—55.0)
Number of visits	347.4	(159.6)	(38.0—679.0)
Diseases of terminally ill patients			
High number of cancer patients	25	(47.2)	
High number of non-cancer patients	11	(20.8)	
Almost same number of cancer and non-cancer patients	15	(28.3)	
Ratio of at-home deaths in 2011	47.4	(24.7)	(5.0—92.0)
< 50%	24	(45.3)	
≥ 50%	25	(47.2)	
Average service term for providing terminal care			
7 days or less	0	(0.0)	
1–2 weeks or less	1	(1.9)	
2–4 weeks or less	14	(26.4)	
1–3 months or less	21	(39.6)	
3–6 months or less	9	(17.0)	
6–12months or less	3	(5.7)	
1–2 years or less	2	(3.8)	
2 years or more	0	(0.0)	
Philosophy of providing end-of-life care			
Yes	33	(62.3)	
No	18	(34.0)	
Seminar information for staff			
Insufficient, a little sufficient, neither	16	(30.2)	
Very sufficient	33	(62.3)	

Notes. N=53. Missing data were not included.

3.2 Opportunity for attending end-of-lifecare seminars

Of the 224 home visiting nurses, 66 nurses (29.5%) reported a complete lack of opportunity to attend end-of-life care seminars. The most frequently reported category was the opportunity to attend "once" (36.6%) (see Table 3).

Table 3. Seminar attendance in 2011

Frequency	Number	%
0 times	66	29.5
Once	82	36.6
Twice	47	21.0
About four times	19	8.5
About six times	5	2.2
More than twelve times	2	0.9

Notes. Missing data were not included.
"End-of-life care seminars" included workshops, study meetings, and case briefing sessions about caring for terminally ill patients and their families.

3.3 Factors relating to attending end-of-life seminars

The chi-square and unpaired t-test results are shown in Table 4. There were 11 factors with a significance of p <0.10 related to attendance at end-of-life care seminars including age, employment status, job status, theagencylocation, proportion of dying patients among total patients, the frequency of visits, the ratio of at-home deaths in 2011, the philosophy of providing end-of-life care, seminar information for staff, autonomy in providing end-of-life care, and experience in caring for terminally ill patients.

Table 4. Relationship between the opportunity for attending end-of-life care seminars and nurses' and agencies' characteristics

Variables	Overall		0 times (n = 66)		At least more than once per year (n = 155)		*P* -value
	Mean or n	(SD) (%)	Mean or n	(SD) (%)	Mean or n	(SD) (%)	
Nurses' characteristics							
Age[£]	25.0	(7.3)	43.2	(6.9)	46.2	(7.3)	.006
Educational background[Ω]							
Two year vocational college	182	(81.8%)	53	(81.5%)	127	(81.9%)	.944
Junior college or university	41	(18.2%)	12	(18.5%)	28	(18.1%)	
Years of home visit nursing experience[£]	6.5	(5.0)	6.7	(5.6)	7.8	(4.6)	.143
Years of working in the current agency[£]	4.9	(4.6)	5.6	(5.5)	6.7	(4.7)	.138
Employment status[Ω]							
Full time	161	(72.9%)	40	(60.6%)	121	(78.1%)	.008
Part time	60	(27.1%)	26	(39.4%)	34	(21.9%)	
Job status[Ω]							
Nursing manager and senior staff member	57	(25.8%)	7	(10.6%)	50	(32.3%)	.001
Visiting staff	164	(74.2%)	59	(89.4%)	105	(67.7%)	

(Table 4 continued on page 122)

Table 4. Continued.

Variables	Overall		0 times (n = 66)		At least more than once per year (n = 155)		*P* -value
	Mean or n	(SD) (%)	Mean or n	(SD) (%)	Mean or n	(SD) (%)	
Experience of caring for terminally ill patients[Ω]							
≤ 10 patients	76	(34.4%)	30	(45.5%)	46	(29.7%)	.024
> 10 patients	145	(65.6%)	36	(54.5%)	109	(70.3%)	
Agencies' characteristics							
Location of agency[Ω]							
Urban	96	(43.4%)	23	(34.8%)	73	(47.1%)	.093
Rural	125	(56.6%)	43	(65.2%)	82	(52.9%)	
Number of nursing staff[Ω]							
< 6 staff	109	(50.7%)	39	(45.5%)	79	(53.0%)	.306
≥ 6 staff	106	(49.3%)	36	(54.5%)	70	(47.0%)	
Number of total patients cared for in 2011[£]	372.0	(565.3)	####	(645.0)	336.6	(531.6)	.177
Number of dying patients cared for in 2011[£]	23.7	(12.3)	22.2	(11.9)	24.4	(12.5)	.250
Proportion of dying patients among total patients[Ω]							
< 20%	100	(51.8%)	39	(66.1%)	61	(45.5%)	.008
≥ 20%	93	(48.2%)	20	(33.9%)	73	(54.5%)	
Frequency of visits[£]	72.8	(23.7)	77.9	(21.7)	70.4	(24.4)	.073
Diseases of terminally ill patients[Ω]							
High number of cancer	113	(52.6%)	36	(54.5%)	77	(51.7%)	.613
High number of non-cancer	48	(22.3%)	12	(18.2%)	36	(24.2%)	
Almost same number of cancer and non-cancer	54	(25.1%)	18	(27.3%)	36	(24.2%)	
Ratio of at-home deaths in 2011[£]	47.1	(24.2)	41.2	(25.1)	50.0	(23.5)	.019
Average service term for providing terminal care							
< 1 month	59	(27.2%)	20	(30.3%)	39	(25.8%)	.495
≥ 1 month	158	(72.8%)	46	(69.7%)	112	(74.2%)	
Philosophy of providing end-of-life care[Ω]							
Yes	71	(33.0%)	28	(42.4%)	43	(28.9%)	.051
No	144	(67.0%)	38	(57.6%)	106	(71.1%)	
Seminar information for staff[Ω]							
Not at all, rarely, occasionally	72	(34.1%)	29	(46.0%)	43	(29.1%)	.017
Often, always	139	(65.9%)	34	(54.0%)	105	(70.9%)	
Schedule support for attending seminar[Ω]							
Insufficient, a little sufficient, neither	103	(46.8%)	35	(53.8%)	68	(43.9%)	.176
Very sufficient	117	(53.2%)	30	(46.2%)	87	(56.1%)	
Autonomy of providing end-of-life care[Ω]							
Strongly disagree, disagree, neither	106	(49.3%)	41	(62.1%)	65	(43.6%)	.012
Agree, strongly agree	109	(50.7%)	25	(37.9%)	84	(56.4%)	

Notes. Missing data were not included. £) Unpaired t-test, Ω) Chi-square test.

Table 5 shows the results ofthemultivariate logistic regression for these factors. Only one variable, autonomy of providing end-of-life care (OR=2.82, 95% CI: 1.07–7.40), showed a significant association with attendance at end-of-life care seminars.

Table 5. Multivariate logistic regression analysis for identifying factors related to opportunities for end-of-life care seminars

Variables	Odds ratio	(95%CI)	*p*-value
Demographic data			
Age	*1.04*	(0.98—1.11)	.166
Employment status (ref: full-time)	*.60*	(0.21—1.75)	.353
Job status (ref: nursing manager)	*.49*	(0.23—1.00)	.052
Experience of caring for terminally ill patients (ref: ≤ 10patients)	*.76*	(0.28—2.01)	.573
Agencies' characteristics			
Location of agency (ref: urban)	*.93*	(0.31—2.76)	.897
Frequency of visits	*.99*	(0.97—1.01)	.340
Proportion of dying patients among total patients (ref: ＜20%)	*2.30*	(0.89—5.96)	.087
Death ratio at home in 2011	*1.78*	(0.59—5.40)	.310
Philosophy of providing end-of-life care (ref: no)	*1.77*	(0.72—4.33)	.210
Seminar information for staff (ref: not at all, rarely, occasionally)	*1.35*	(0.53—3.44)	.535
Autonomy of providing end-of-life care (ref: strongly disagree, disagree, neither)	*2.82*	(1.07—7.40)	.035

Note. Opportunity for end-of-life care seminars：0 = 0 times, 1 = at least more than once per year
ref: reference, CI: confidence interval, $p < 0.05$

4 Discussion

This study identified the opportunity for attending end-of-life care seminars and related factors. There are two main findings of this study. First, approximately 30% of home visiting nurses had a complete lack of opportunity to attend end-of-life care seminars. Second, nurses who hadmore autonomyin decision-making when providing terminal care were givenmore opportunities to attend seminars on end-of-life care.

4.1 Opportunities for attending end-of-life care seminars

Approximately 30% of participants did not have any opportunity to attend end-of-life care seminars in 2011. End-of-life care is often included as a learning content area of concern among home visiting nurses. Previous studies, which focused on the learning needs of home visiting nurses, have reported that end-of-life care was a frequently reported domain [17]. This result could mean that home visiting nurses are not able to fulfill their learning needs. Laschinger et al (2009) insisted that the lack of time and resources meant professionals could only deal with the immediate issues raised by patients; this fact causes patients and families to have a lower quality of life [18]. Therefore, the agency has a responsibility to the staff to ensure time and human resources in order for them to continue learning about end-of-life care.

Potentially, nurses might not have attempted to participate in seminars, at least in 2011. On-the-job training can be gradually introduced through the use of an e-learning system. In addition, peer-discussion within each agency provides more creative nursing practices based on shared professional knowledge and skills during each case discussion. In this study, there were only two nurses (1.8%) who had experience working in palliative units or hospices, however,

participants need more unique skills in home visiting nursing than in institutional nursing. Future research is needed to determine unmet learning needs and then establish ways of meeting those needs, as well as increase the actual number of nurses in attendance, and provide concrete contents in the seminars.

4.2 Autonomy of providing end-of-life care and attendance at end-of-life care seminars

Nurses could attend more end-of-life care seminars when they had more autonomy to make decisions about the terminal care they provided. A possible explanation of this result is that autonomy increased the nurses' motivation and therefore made them proactive about learning. This relationship might also be explained by the Job Demands-Resources model (JD-R model) [19]. The JD-R model explains why autonomy makes employees more engaged in their jobs and why engaged employees seek out opportunities to learn proactively [20]. This mechanism is referred to as the motivational process in the JD-R model. The motivational process explains how job resources predict employees' work engagement and positive work attitudes [21]. Concerning job resources, previous studies have identified support from superiors or colleagues, feedback, and job autonomy, as important. Among them, job autonomy is known to be a predictor of work engagement [22], and this has been shown among nurses [23, 24] and home visiting nurses [25]. By being given autonomy when nurses are providing end-of-life care, nurses might engage more in end-of-life care. Similar results in previous study was shown in that nurses who had more autonomy showed more positive attitudes toward caring for dying patients [26]. And then, engaged nurses might have also sought opportunities to attend end-of-life care seminars in order to attain more accurate knowledge and skills and to improve their comprehension of patients' and families' needs.

4.3 Study limitations

This study has several limitations. First, the validity and reliability of the results might be weakened by the use of an original measurement for the outcome variable. Treating the number of opportunities for attendance at end-of-life care seminars as a dependent variable was risky, to some extent, in interpreting the results because some participants might choose not to attend end-of-life care seminars for both positive and negative reasons. For example, if nurses have fewer terminally ill patients and already have professional skills from prior end-of-life care seminars, they might choose not to attend. However, this study offers a manageable variable that nursing managers can observe and intervenein to improve their staffs' end-of-life care skills.

Second, the participants in this study came from only one prefecture in eastern Japan. This selection bias limits the generalizability of the results. Future research is needed from different countries because the relationship between nurses' autonomy and educational opportunities has not been clarified under different ecological systems.

Finally, the sample size was slightly small according to the results of calculation about sample size. If possible, additional examinations should be conducted with a sufficient sample. While, the authors considered that this problem made a minimal impact on the results of this study. Nevertheless we found positive relationship between autonomy and attendance at end-of-life care seminars, our study design could not reveal their causal relationship. Future research is required to detect it and implicate how nursing managers can improve their staff nurses' attendance for end-of-life care seminars.

5 Conclusion

This study was conducted to identify factors related to opportunities for home visiting nurses to attend end-of-life care seminars. Being given autonomy in providing end-of-life care was associated with attendance at end-of-life care seminars. These results may provide specific information for nursing managers to improve the quality of end-of-life care among nursing staff by ensuring staff's autonomy.

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Conflict of interest

No conflict of interest has been declared by the authors.

References

[1] Kolanowski R. Japan's Gold Plan emphasizes home care and the consumer. Caring. 1997; 16(4): 38-40. PMid:10167040

[2] Nakane J, Farevaag M. Elder care in Japan. Perspectives (Gerontological Nursing Association (Canada)). 2004; 28(1): 17-24.

[3] Matsuda S. The health and social system for the aged in Japan. Aging clinical and experimental research. 2002; 14(4): 265-270. PMid:12462371 http://dx.doi.org/10.1007/BF03324449

[4] Ministry of Labour Health and Welfare. The current situation and the future direction of the Long-term Care Insurance System in Japan with a Focus on the Housing for the Elderly. 2013. Available from: http://www.mhlw.go.jp/seisakunitsuite/bunya/kenkou_iryou/iryou/zaitaku/index.html.

[5] Nagata S, Taguchi A, Naruse T, Kuwahara Y, Murashima S. Actual situation and characteristics of clients judged to need home-visiting nurse services by certified care managers and comparison of users and non-users of such services. Nihon Koshu Eisei Zasshi. 2010; 57(12): 1084-1093. PMid:21348283

[6] Naruse T, Nagata S, Taguchi A, Murashima S. Classification tree model identifies home-based service needs of Japanese long-term care insurance consumers. Public health nursing (Boston, Mass). 2011; 28(3): 223-232. http://dx.doi.org/10.1111/j.1525-1446.2010.00915.x

[7] Burt J, Shipman C, Addington-Hall J, White P. Nursing the dying within a generalist caseload: a focus group study of district nurses. International Journal of Nursing Studies. 2008; 45(10): 1470-1478. http://dx.doi.org/10.1016/j.ijnurstu.2008.01.00

[8] Karasawa K, Yasuda K, Mikoshiba Y, Sakai K, Shimomura S, Kitayama A, et al. Current Status in-Service Training and Learning Needs of Home-Visit Nurses in Nagano Prefecture (1st Report): Analysis of the Questionnaire Survey of Nurse Managers Bulletin Nagano College of Nursing 2011;13:17-27.

[9] Shih FJ, Gau ML, Lin YS, Pong SJ, Lin HR. Death and help expected from nurses when dying. Nurs Ethics. 2006; 13(4): 360-375. http://dx.doi.org/10.1191/0969733006ne881oa

[10] Kuwahara Y, Nagata S, Taguchi A, Naruse T, Yamaki S, Tagami Y, et al. Classification of home visiting nurse clients according to proportion of direct/indirect tasks. Journal of the Japan Society for Healthcare Administration. 2012; 49(4): 227-237.

[11] Nagata S, Kuwahara Y, Taguchi A, Naruse T, Murashima S. Visiting Nurses' Work Contents and Time Spent According to Client Condition: Focused on Work Order Than Direct Care. Journal of Japan Academy of Home Health Care. 2013; 16(2): 61-68.

[12] Tomison G, McDowell JR. Nurses' needs in delivering palliative care for long-term conditions. Br J Community Nurs. 2011; 16(6): 274-276, 278-281. PMid:21642911 http://dx.doi.org/10.12968/bjcn.2011.16.6.274

[13] Hekelman FP, Niles SA, Snyder CW, Stricklin ML. The time has come--a study of geriatric continuing education in Ohio Visiting Nurse Associations. Journal of continuing education in nursing. 1995; 26(6): 267-271. PMid:7494073

[14] Cumming M, Boreland F, Perkins D. Do rural primary health care nurses feel equipped for palliative care? Australian journal of primary health. 2012; 18(4): 274-283. http://dx.doi.org/10.1071/PY11150

[15] Iguchi H, Kobayashi R. Nagano ken houmonn kanngo kennshuu jyukousha gennshou youinn ni tuiteno kousatsu. Naganokenn kanngo kennkyuu gakkai ronnbunnshu. 2012; 30: 40-42.

[16] Welfare and Medical services. 2012. Available from: http://www.wam.go.jp/content/wamnet/pcpub/top/.

[17] Karasawa K, Yasuda K, Mikoshiba Y, Sakai K, Shimomura S, Kitayama A, et al. Current Status in-Service Training and Learning Needs of Home-Visiting Nurses in Nagano Prefecture (2nd Report): Analysis of the Questionnaire Survey of Nursing Staff. Bulletin/Nagano College of Nursing. 2012; 14: 25.

[18] Laschinger HKS, Wilk P, Cho J, Greco P. Empowerment, engagement and perceived effectiveness in nursing work environments: does experience matter? Journal of Nursing Management. 2009; 17(5): 636-646. http://dx.doi.org/10.1111/j.1365-2834.2008.00907.x

[19] Demerouti E, Bakker AB, Nachreiner F, Schaufeli WB. The job demands-resources model of burnout. The Journal of applied psychology. 2001; 86(3): 499-512. http://dx.doi.org/10.1037/0021-9010.86.3.499

[20] Sonnentag S. Recovery, work engagement, and proactive behavior: a new look at the interface between nonwork and work. Journal of Applied Psychology. 2003; 88(3): 518-528. http://dx.doi.org/10.1037/0021-9010.88.3.518

[21] Schaufeli WB, Bakker AB. Job demands, job resources and their relationship with burnout and engagement: A multi-sample study. Journal of Organizational Behavior. 2004; 25: 293-315. http://dx.doi.org/10.1002/job.248

[22] Shimazu A, Schaufeli WB. Work engagement: an emerging concept in occupational health psychology. Biosci. 2008;2(1):171. http://dx.doi.org/10.1080/02678370802393649

[23] Simpson MR. Engagement at work: a review of the literature. International Journal of Nursing Studies. 2009;46(7):1012-1024 http://dx.doi.org/10.1016/j.ijnurstu.2008.05.003

[24] Sakai M, Naruse T, Watai I, Arimoto A, Murashima S. A literature review on work engagement of nurses. Journal of Japan Academy of Nursing Science. 2012; 32(4): 71-78. http://dx.doi.org/10.5630/jans.32.4_71

[25] Tourangeau A, Patterson E, Rowe A, Saari M, Thomson H, Macdonald G. Factors influencing home care nurse intention to remain employed. J Nurs Manag. 2013. http://dx.doi.org/ 10.1111/jonm.12104

[26] Miyashita M, Nakai Y, Sasahara T, Koyama Y, Shimizu Y, Tsukamoto N. Nursing autonomy plays an important role in nurses' attitudes toward caring for dying patients. American Journal of Hospice & Palliative Medicine. 2007; 24(3): 202-210. http://dx.doi.org/ 10.1177/1049909106298396