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Introduction

The majority of nursing schools fall short of producing adequate education, despite the international champion for includes hospice education in the nursing bachelor's degree [1]. Many reasons, such as short programme duration, insufficient practise units, too cautious clinical instructors, high levels of stress in actual hospice situations, and students' difficulties bringing theory to the clinic, led to the poor instruction. Since hospice clinical practise could not always be guaranteed, hospice speculative learning was blended into other topics. Students with shy schooling were unprepared for hospice care. Via an online survey, Chover-Sierra et al. discovered that the data on hospice care for 619 nursing students was moderately low [2].

According to the descriptive research, 187 junior nursing students were shy and self-sufficient in providing hospice care [3,4]. Students' negative perceptions of hospice care were caused by secretive data, which is likely what reduced the availability of high-quality hospice treatment. Nursing standards are lowered as a result of insufficient education for nurses. According to Marchan's analysis, few nursing personnel feel comfortable caring for the terminally ill [5]. Educational approaches in hospice care benefited from the efforts of educators. For instance, a research that supported medical students' knowledge and perspective on hospice medications [6] verified the beneficial benefits of hospice education, which consists of sixteen hours of lectures. In order to improve participants' perceptions of hospice, attitudes towards death, and ways of living, Choi employed a hospice programme consisting of 10 3-hour sessions. Choi's teaching methods included lecture, video watching, presentation, and discussion [7]. With the use of standardised patients in a hospice simulation, Tamaki et al. increased the data, ability performance, and authority of their pupils [8]. In earlier research, a wide range of instructional techniques, including clinical practise, instructive instructions, and simulation-based activities, were used [9]. While the clinical application offered students real-world engagement, the instructional guidelines were effective at imparting knowledge. The limited options for hospice clinical practise put less emphasis on the simulation-based approach. As AN experiential learning methodology, the simulation was progressively accepted as a preparation, substitute, or supplement for hospice clinical applies. Simulator-based activities were the initial instructional technique and were regarded as beneficial and helpful for learning in end-of-life teaching programmes, according to one systematic evaluation that covered the programmes from 2008 to 2018 [10]. Turkey's demographic statistics indicate that the average life expectancy is 78 years, and the top three leading causes of death are chronic illnesses including cancer, circulatory system disorders, and respiratory system diseases. In addition, the country's population is ageing every other day1 due to the 8.2% senior population that it now has. Moreover, patients who require palliative care typically get treatment in emergency rooms and critical care units for symptom management. These results demonstrate that palliative care is becoming increasingly necessary in Turkey. The four primary subjects for hospice and palliative care have been the focus of the worldwide association for these two fields. They include methods for providing palliative care that is affordable, gaining access to medications, implementing health policy, and providing such services. A comprehensive strategy that includes a group of skilled professionals, hospital collaboration, required legal arrangements, and well-coordinated home care services may deliver high-quality palliative care.

Palliative care seeks to enhance patients' quality of life by easing their emotional, spiritual, and physical pain. Several studies in the literature have found that educational interventions have a favourable

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