

Research Article

Experiences and Practices of Nurses Providing Palliative and End-of-Life Care to Oncology Patients: A Phenomenological Study

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Cite this article as: Durmuş Sarıkahya, S., Gelin, D., Çınar Özbay, S., & Kanbay, Y. (2023). Experiences and practices of nurses providing palliative and end-of-life care to oncology patients: A phenomenological study. *Florence Nightingale Journal of Nursing*, 31(S1), 22-30.

Abstract

AIM: The objective of this study was to describe the experiences and practices of nurses who provide palliative and end-of-life care to oncology patients, to determine the difficulties they encounter in this regard, and to determine how they cope with it.

METHOD: Data were collected between December 10 and 27, 2022, at a hospital's palliative care clinic. The descriptive phenomenological approach, which is a qualitative research method, was used in this study. The sample of the study consisted of 12 nurses who provided palliative and end-of-life care to oncology patients in a city hospital. The research data were collected with the nurse descriptive form and a semi-structured interview form. Descriptive statistics and the thematic content analysis method were used in the analysis of the data.

RESULTS: The themes that emerged as a result of the interviews with nurses who provided palliative and end-of-life care to oncology patients in palliative units were "various learning experiences," "responsibilities in caregiving," "nursing care practices," "personal motivation sources for nurses," "difficulties," and "experience in coping with difficulties."

CONCLUSION: In this study, it was determined that nurses who provide palliative and end-of-life care to oncology patients are exposed to some difficulties as a result of their professional experience, that, in addition, they had various learning experiences, and that their coping skills were team cohesion and training. In line with the results of the study, it is recommended to structure palliative in-service training after graduation, to arrange for palliative care centers, and to consider the problems experienced in determining the needs.

Keywords: End-of-life care, nursing practices, palliative care, qualitative research

Introduction

Palliative care includes practices for the prevention and alleviation of suffering pain by meeting the physical, psychological, social, and spiritual needs of individuals (adults and children) with life-threatening diseases and their families when they are faced with the problems associated with such diseases and has been defined as an approach aimed at increasing the quality of life, dignity, and comfort (Farfán-Zúñiga & Jaman-Mewes, 2021). According to the World Health Organization (WHO), palliative care is defined as the prevention and alleviation of the suffering of adult and pediatric patients (World Health Organization, 2020).

Palliative care primarily comes into view in the context of care aimed at controlling the pain and other symptoms of people with oncological diseases. However, with the increase in the number of individuals with chronic and life-threatening, incurable diseases and the aging population, cardiovascular diseases, cirrhosis, chronic obstructive pulmonary disease, human immunodeficiency virus/acquired immunodeficiency syndrome,

multiple sclerosis, tuberculosis, diabetes, cerebrovascular disease, neurodegenerative disorders, problems related to injuries, and old age are included in the palliative care approach (Connor, 2014).

Extended life expectancy increases the complexity of care and the demands for palliative care (Afshar et al., 2021). It is reported that each year an estimated 56.8 million people worldwide, of whom 25.7 million are in the last 1 year of their life, need palliative care, of which only 14% of this demand is met (World Health Organization, 2020). The role, knowledge, communication, and attitude of nurses, who are present from the moment of diagnosis to the progression of the disease, including death and mourning after death and who are an important member of the team, play a key role in improving the quality of life of the patient (Kıyak et al., 2022; Martínez-Sabater et al., 2021). It is necessary to provide comprehensive continuous care with the cooperation of the patient and his family, give early information on palliative care in the diagnosis of a life-threatening and serious disease, to provide interdisciplinary cooperation and communication, and to reduce

the physical, psychological, emotional, and spiritual distress of the patient and his family. During this entire process, the knowledge of the nurses, symptom management with effective communication and an empathetic approach, as well as the ability to think critically and to evaluate contribute to the holistic care of people with chronic and life-threatening diseases and their families. Therefore, it is essential to possess sufficient end-of-life and post-mortem knowledge and skills (Soikkeli-Jalonen et al., 2020).

When recent literature on the subject is examined, the lack of knowledge of nurses on palliative care is defined as a constant obstacle for healthcare professionals who strive to improve palliative care (Moir et al., 2015). Studies conducted in several countries among nurses working in different nursing care fields indicate that nurses experience a lack of knowledge while managing the care of such patients (Hökkä et al., 2021; Soikkeli-Jalonen et al., 2020). This lack of knowledge has been revealed by the results of qualitative research and evaluations with regard to nurses who stated that they needed more training on palliative care.

Another qualitative study revealed that nurse communication and support are effective in helping cancer patients face psychological weakness and reduce their pain, accepting palliative care, and coping with their situation (Seyedfatemi et al., 2014). In a study conducted in Spain, an effort was made to determine the level of knowledge and experience of nurses with regard to palliative care, and it was determined that nurses who had received training in palliative care had higher levels of knowledge compared to those who did not and that nurses who had palliative care experience had higher levels of knowledge compared to those who did not have experience in this field (Martínez-Sabater et al., 2021).

More qualitative studies are needed to provide effective palliative nursing care, to manage patients, and to determine their needs. In the light of these findings, an in-depth analysis of the learning experiences of nurses, their care practices and the difficulties they experience during these practices, as well as their experience in coping with difficulties and their sources of motivation will be a necessary step in arranging for palliative care centers and creating strategies for solving the problems of nurses in providing care.

Concurrently, having knowledge about the experiences and needs of nurses during the practice will also help to strengthen the determination of the palliative education program with regard to the nursing education content. This study was carried out to determine the opinions of nurses caring for oncology patients about their experiences in a qualitative manner. This study may provide valuable information about the experiences of nurses, their learning process, difficulties they encounter during their practices, and how they cope with the difficulties they experience.

Research Questions

The research questions in this study were as follows:

1. What is the experience of nurses in caring for patients with oncology?

2. What are the practices of nurses in caring for patients with oncology?
3. What are the most important challenges for nurses in caring for patients with oncology?

Method

Study Design

We used consolidated criteria for reporting qualitative study guidelines for our study (Tong et al., 2007). Phenomenology is a qualitative research approach that seeks to answer the question "What is the meaning, structure and essence of events experienced by a particular person or persons?" (Lindseth & Norberg, 2004). The phenomenological research design was chosen to explain the experiences and practices of nurses providing palliative and end-of-life care and the meaning of palliative and end-of-life care.

Sample

In qualitative research, individuals are selected for interviews based on whether they are directly related to the research topic rather than their ability to represent the population. The most important indicator in the selection of the study group in the phenomenological design is that it consists of individuals who have experienced all aspects of the phenomenon which is being studied (Palinkas et al., 2015). The sample of the study was formed by nurses who provided end-of-life care to oncology patients in the palliative unit of a city hospital. The research was carried out with 12 nurses working in the palliative care clinic of a city hospital in Turkey between December 10 and 27, 2022. The purposive sampling method was used in the study. In purposive sampling, the aim was to identify a sample that meets certain predetermined criteria. The sample size was determined by the repetition of the data (reaching the saturation point), and a total of 12 interviews were conducted (Yildirim & Simsek, 2008). The inclusion criterion for the sample was that the nurses had to have more than 1 year of working experience at a palliative care clinic.

Data Collection Tools

The study data were collected with the nurse descriptive form and semi-structured interview form.

Nurse descriptive form: The descriptive form consists of 10 questions regarding the personal and professional characteristics of nurses (age, gender, education level, duration of employment, and duration of employment at the unit).

Semi-structured interview form: The semi-structured interview form was created by the researchers in accordance with the purpose of the study and consists of 12 questions. Semi-structured individual interviews were conducted using an interview guide (Table 1).

An appropriate date and time was determined for individual interviews with the nurses who agreed to participate in the study. Written consent was obtained from the nurses who volunteered to participate in the study, and permission was obtained to use a voice recorder during the interviews. During

Table 1.
Guide for Preparing Interview Questions

1. What does care for oncology patients receiving palliative and end-of-life care mean to you?
2. What are the emotions you experience while giving palliative or end-of-life care to a patient?
3. Which care practices do you apply as a palliative care nurse?
4. What do you think should be the most appropriate care for an oncology patient receiving palliative or end-of-life care?
5. Do you receive feedback from patients or their relatives about the nursing care you provide to patients? If yes, what does it mean to you?
6. What kind of difficulties do you encounter while giving care?
7. What are the most difficult subjects for you?
8. How do you cope with the problems you experience?
9. What would you recommend for more effective palliative and end-of-life care in palliative care units?
10. How do you provide motivation during the palliative care process?
11. What did you gain from working at this unit?
12. Is there anything else you would like to add?

the study, data were collected with the semi-structured interview technique. In-depth interviews were conducted on the basis of open-ended questions in a peaceful and calm environment at the palliative care unit and took 45–60 minutes. During the interview, the interviewer and the interviewees were seated at the same level, the participants actively listened, and questions were asked. The maturation and saturation of the data collected during the process (the point where data repeated, additional data were absent, new information or opinions were not obtained, and all research questions were answered) were observed as a criterion for the termination of the process.

Validity and Reliability of the Study

For the validity and reliability of the study, the Lincoln and Guba (1985) criteria were taken into account, which are as follows: credibility, dependability, confirmability, and transferability. To confirm the reliability of the findings, the participants reviewed what was written by the researchers by recognizing themselves

in the process, also known as member checking. The method and analysis were explained in detail to ensure reliability. The researchers evaluated the information independently, and triangulation was carried out throughout the study to increase the reliability of the findings and compare the bias of researchers. For confirmability, records of the process were documented, in order for others to check those records. This process is called an audit trail. Finally, the sample and environment for data transferability were explained in detail.

Statistical Analysis

The obtained interview records were transcribed, and the interpretative phenomenological analysis proposed by Colaizzi was used as a basis for the analysis of the data. The stages of analysis used by Colaizzi (1978) in his phenomenological studies are as follows: (1) registering the record, (2) uncovering the meaning of the explanations, (3) expressing the meanings precisely and clearly, (4) organizing the explanations into clusters of themes, (5) describing in detail, (6) explaining the basic structure of the phenomenon, and (7) formulating the basic structure of the phenomenon. The documents were read verbatim several times by the researchers, resulting in a broad and general understanding of the content. In this stage, the sentences were analyzed, and meaningful expressions were obtained. Afterward, the sentences and sentence structures in the data were coded independently according to the scope of focus. All researchers identified themes and subthemes to represent these codes through iterative discussion until consensus was reached. Themes and subthemes were integrated into a comprehensive description of the palliative and end-of-life care experiences of nurses. All researchers independently identified themes that were clarified through iterative discussion until consensus was reached. In presenting the findings related to the themes, the researchers aimed to increase the validity by including direct quotes from the opinions of the participants.

Ethical Considerations

Prior to data collection, the necessary ethics committee permission (number: E-18457941-050.99-68824, date: 01.11.2022)

Table 2.
Demographics of Participating Nurses (n=12)

Participants	Age (Years)	Gender	Marital Status	Educational Level	Working Experience (Years)	Working Experience in a Palliative Care Clinic (Years)
Nurse 1	22	Female	Married	Bachelor's degree	8	1
Nurse 2	32	Female	Married	Bachelor's degree	11	2
Nurse 3	44	Female	Married	Bachelor's degree	22	4
Nurse 4	23	Female	Single	Associate's degree	4	1
Nurse 5	24	Female	Single	Associate's degree	4	2
Nurse 6	32	Female	Married	High school graduate	13	6
Nurse 7	25	Female	Single	Bachelor's degree	3	1
Nurse 8	36	Female	Married	Bachelor's degree	16	3
Nurse 9	26	Female	Married	Bachelor's degree	5	1
Nurse 10	40	Female	Married	Bachelor's degree	15	2
Nurse 11	35	Female	Married	Bachelor's degree	12	2
Nurse 12	29	Female	Married	Bachelor's degree	5	5

Table 3.
Themes and Categories Extracted from Content Analysis

Themes	Subthemes
Various learning experiences	Spiritual growth and development
	Connection and communication with patient and family
	Giving life meaning: life and death
Responsibilities in providing care	Maintaining a sense of hope
	Providing moral support
Nursing care practices	Self-care requirements
	Pain management
	Wound care
	Psychological support
Personal sources of motivation for nurses	Social activities within the team
	Positive feedback from the patients and their relatives
	Feeling useful
Difficulties	Difficulties in communicating with patients/relatives
	Excess of reactions and expectancies of relatives
	Not being able to alleviate the pain
	Physically inadequate environment at the clinic
Experience in coping with challenges	Team cohesion
	Continuous professional education

and institutional permission were obtained. Participation in the study was on a voluntary basis. After the nurses to be included in the sample of the study were informed about the purpose of the study, their written consent was obtained with regard to the fact that they volunteered to participate in the study.

Results

Characteristics of the Respondents

In-depth interviews were conducted with 12 nurses providing palliative and end-of-life care to oncology patients (see Table 2: nursing-related factors and demographics). A percentage of 50.0% of the nurses stated that they received training on palliative care, 83.3% stated that they willingly chose to work at the palliative care unit, and 66.6% stated that some of their relatives were diagnosed with cancer.

Phenomenology

Six themes were determined from the findings obtained as a result of the interviews with the participants (Table 3). These are as follows: "various learning experiences," "responsibilities in providing care," "nursing care practices," "personal sources of motivation for nurses," "difficulties," and "experience in coping with challenges." The nurses who have been quoted have been listed according to their interview order and abbreviated as N1, N2, etc. (Table 4).

Theme 1: Various Learning Experiences

The experience of nurses in a palliative care unit has fostered multiple learning outcomes: (1) at the spiritual level, (2) connection and communication with the patient and his family, and (3) making sense of life: life and death. Palliative care nurses have discovered the spiritual dimension of the patient and their family as well as their own spiritual development. Nurses stated that they reevaluated some concepts in their lives and reevaluated existential questions from their own perspective regarding their experiences. They stated that they observed that this process, which they experienced together with the patients, had a counterpart in their own lives as well. They emphasized the value of understanding spiritual needs. They also stated that connecting and communicating is an important part of the experience.

Theme 2. Responsibilities in Providing Care

While some of the participants stated that nurses have a responsibility to maintain the feeling of hope for patients receiving palliative and end-of-life care until the end, others stated that they provide moral support to the patients.

Theme 3. Nursing Care Practices

Nurses stated that they mostly met needs with regard to self-care, pain management, wound care, and psychological support.

Theme 4. Personal Sources of Motivation for Nurses

Despite the difficult conditions and difficulties, most of the nurses caring for palliative patients reported that their personal sources of motivation made them happy. The personal motivation sources of nurses were as follows: (1) social activities within the team, (2) team cohesion, (3) positive feedback from patients and their relatives, and (4) feeling useful.

Theme 5. Difficulties

The difficulties experienced by the nurses participating in the study in communicating with the patient/patient relatives while providing patient care, the reactions and expectations of the relatives of patients, the inability to relieve pain, and the inadequacy of the physical environment at the clinic reflected negatively on the care.

Theme 6. Experience in Coping with Challenges

Pediatric nurses stated that team cohesion and continuous professional training were important factors that shaped their experiences throughout their professional life.

Discussion

With this study, it was found that the experience of nurses providing palliative and end-of-life care to oncology patients at a palliative care unit was satisfactory with meaningful learning, despite challenges. It was also emphasized that nurses have responsibilities in maintaining a sense of hope by supporting patients psychologically and spiritually during palliative and end-of-life care.

Findings indicated that, as a result of working at the palliative unit, the meaning and value of life became more evident for the nurses, who learned to control stress and anger, to be patient and tolerant, and whose perception of accepting death

Table 4.
Themes, Subthemes, and Sample Quotes Identified in Interviews with Nurses.

Theme	Subtheme	Quotes
Various learning experiences	Spiritual growth and development	<ul style="list-style-type: none"> I have become more conscious, logical, mature and patient towards life. (N1) My biggest learning outcome is that my perspective towards life has changed. Being more understanding, coping with problems I experience and not thinking "what if"... (N2) Working at this unit has increased my compassion, anger management, patience and tolerance. (N4) Working at this unit has taught me how nothing matters in life and how to enjoy the moment. Nothing is more important than health. (N6) I saw how meaningless the things I longed for in life actually were. I learned to better recognize what I value in life and to be grateful. (N7) I learned to be patient and faithful. I can control my sadness, stress and anger. (N10)
	Connection and communication with patient and family	<ul style="list-style-type: none"> Communicating with patients, listening to them and being with them during their last moments, rather than just treating them makes me happy. (N1) The most appropriate care for an oncology patient receiving palliative or end-of-life care is communication with the patients and their relatives. (N2) Working at this unit allowed me to empathize with patients and their relatives. (N5)
	Giving life meaning: life and death	<ul style="list-style-type: none"> I am more patient, livelier. I have learned to control my emotions. I came to accept that death is as normal as birth. (N8) Working with palliative patients has taught me a lot of patience and tolerance. I became a professional in controlling my emotions. I realized that death is a normal process. (N12)
Responsibilities in providing care	Maintaining a sense of hope	<ul style="list-style-type: none"> The most appropriate care is the care that connects them to life. To relieve a patient of his intense pain in his last days, to communicate in a positive manner and, if necessary, to bring him the light he is longing for and make him happy. (N1) Sometimes I compare my patients to a lost acquaintance. I give my patients special attention and care. I'm glad that at least they do not suffer pain exhaling their last breath. (N11)
	Providing moral support	<ul style="list-style-type: none"> Helping patients who cannot manage themselves in their last stage of life, who cannot take care of themselves and who need support is very valuable to me. (N1) Even though it is psychologically exhausting to witness this difficult stage that the patients and their relatives go through during the last moments of patients' life, providing the best quality support that can be given to the patients and their relatives and passing this stage in the most comfortable way possible gives me a feeling of happiness. (N2) Providing comfort to the patient, increasing the quality of life and providing moral support to his relatives. (N8) While improving the quality of life of patients, moral support should be offered to their relatives also. (N12)
Nursing care practices	Self-care requirements	<ul style="list-style-type: none"> We provide oral care, full body care. (N5) We provide personal and emotional care to patients. (N6) We provide oral, face, eye, body, perineal care to patients. (N9) I provide genital, oral care and look after general body hygiene. (N8)
	Pain management	<ul style="list-style-type: none"> The most important problem of palliative patients is usually pain. Care practices to reduce pain become important. (N2). To relieve pain, I provide psychological support in pain control. (N8)
	Wound care	<ul style="list-style-type: none"> I position the patient to protect from bedsores. I routinely let them do exercises in bed. (N8) I provide bed care. I dress wounds if they suffer from bedsores and change their position. (N11)
	Psychological support	<ul style="list-style-type: none"> We meet their psychological and physical needs. We provide morale and motivation to patients. (N7) Music performances and movie screenings should be organized in order to shield patients and their relatives against stressful and tense situations. (N8) I think that psychological support is the most important form of palliative care. (N9) We do our best for patients and their relatives. When medical treatment is insufficient, I try to support the patient psychologically. (N10) Psychotherapy should be given to patients and their relatives, social activities should be organized. (N11) Social and supportive activities should be organized for patients and their relatives. (N12).

(Continued)

Table 4.
Themes, Subthemes, and Sample Quotes Identified in Interviews with Nurses. (Continued)

Theme	Subtheme	Quotes
Personal sources of motivation for nurses	Social activities within the team	<ul style="list-style-type: none"> • The social activities organized by our supervisor make me happy. (N6) • There should be more social activities. (N8) • Motivational trips, nature walks, etc. for the employees could be organized. (N12)
	Positive feedback from the patients and their relatives	<ul style="list-style-type: none"> • We always get positive feedback. Efforts made to ensure that patients have a comfortable, pain-free and qualitative time during the last stage are appreciated. (N2) • The thanks and appreciation I receive from the relatives of patients makes me say that I am glad to serve these patients. (N4) • The prayers and thanks of the patients and their relatives make me happy. (N5) • The smiles and prayers of the patients increase my motivation. (N5) • The positive feedback (prayers, smiles, thanks) I receive from patients and their relatives gives me professional satisfaction. (N8) • Feedback received on the care given is very important for us, both in identifying deficiencies, if any, and in obtaining professional satisfaction. (N10)
	Feeling useful	<ul style="list-style-type: none"> • Motivational practices (such as music, chatting) for the morale of patients or organizing events such as celebrations, being able to make patients smile, provides morale. Another issue that motivates palliative nurses is to alleviate the pain of patients who usually are in a lot of pain, in order to ensure comfortable sleep at night. Shortly, it motivates us to see the patients relax, be peaceful and to reduce their symptoms as much as possible. (N2) • It motivates me when I relieve the distress of patients, when I see a smile on their faces and when I hear patients and their relatives wish me well. (N12)
Difficulties	Difficulties in communicating with patients/relatives	<ul style="list-style-type: none"> • In fact, we do not experience much difficulty while providing care. Patients who make it difficult for us go through psychological processes. Death and post-mortem fears and physical problems they develop negatively affect the communication with them. (N2) • The fear of death and persistent pain, which develop due to difficulties caused by disease in patients, result in communication problems with the patients. They can become more aggressive by the day. The most difficult issue is communication. (N2) • Since the relatives of the patients are anxious (especially when the patient complains of pain), problems arise in communication. (N7) • At times, I experience communication problems with relatives while positioning the patient and providing pain management. (N8) • Anxiety and sadness in patient relatives make communication difficult. (N10)
	Excess of reactions and expectancies of relatives	<ul style="list-style-type: none"> • Patients' relatives are usually tired when they come to the unit. They are not able to accept the disease of the diagnosed patient. They're usually in denial. (N11). • The relatives of the patients who are in their last stage still think that there is hope. Them getting used to it, not accepting death is challenging for me. (N12). • Sometimes we come across unknowledgeable patient relatives. They interfere with what we do. (N1)
	Not being able to alleviate the pain	<ul style="list-style-type: none"> • I feel sad if the patient is deteriorating and feels helpless. (N7) • When the patient's pain does not decrease, I feel sad and helpless. That affects my psyche negatively. (N8) • Patients usually have a lot of pain. Sometimes none of the treatments relieve their pain. I have a hard time in this situation. (N9) • Sometimes I am incapable of relieving pain. When the patient dies, I find it difficult to support his relatives. (N10)
	Physically inadequate environment at the clinic	<ul style="list-style-type: none"> • There should be palliative care homes, appropriate physical conditions should be provided so that they can communicate with other patients' relatives in a more adequate manner. (N10) • The number of palliative units should be increased and appropriate physical conditions should be provided for patients and their relatives. (N11) • Physical conditions should be provided for patients and their relatives, who maybe spend months in just a single room and activities should be organized at regular intervals at the unit. (N12)
Experience in coping with challenges	Team cohesion	<ul style="list-style-type: none"> • A great team can suppress the problems. (N1) • I keep myself motivated by sharing with my teammates. (N7) • I can deal with problems by talking with team members. (N11) • I try not to take the negative accusations, disturbing and hurtful comments of patient relatives personally. In times of stress and anger, I do not respond to anyone. It's good to cool down a few seconds. I try to forget by sharing with my teammates. (N12)
	Continuous professional education	<ul style="list-style-type: none"> • Professional education should be increased. (N8) • Internal practice guidelines for the clinic should be formed and implemented. (N9) • Training should be given to patients and their relatives in order to ensure continuity in treatment and care. (N10)

increased. Similarly, studies confirm that nurses caring for cancer patients in advanced stages have similar experiences, such as the reconsideration of their perspectives and priorities and even expressing personal development (Errasti-Ibarrondo et al., 2018). Spirituality is an important issue reported in the palliative care literature (Balboni et al., 2017) and by patients (Garcia-Rueda et al., 2016). Improving the understanding of spiritual needs provides better recognition and treatment to relieve the suffering of patients and families (Puchalski et al., 2014). In order to increase the quality of care, it is recommended that all members of the healthcare team learn about spiritual care and develop feelings of compassion, reflection, and self-care practices (Balboni et al., 2017).

Nurses working at palliative care units often face serious problems that threaten the lives of individuals and, as a result, witness death (Jang et al., 2019). This experience resulted in nurses going beyond the professional aspect in order to reflect on questions that concern personal development. The fact that nurses developed positive attitudes toward death is an important finding in this study for qualified end-of-life care. Concurrently, this is necessary for nurses providing palliative care in interpreting their professional experiences correctly and planning their next steps accurately. In the literature, it is reported that nurses who receive adequate training on end-of-life care show accepting behavior toward death and are able to provide care within the scope of positive components of death (Chochinov et al., 2016; Henochoa et al., 2017). The results obtained in line with these findings are parallel with that of the literature.

One of the requirements for success in palliative care is effective communication with patients and their relatives, which is a fundamental component of quality care provided to these patients (Yaşar et al., 2020). In the study, nurses stated that the most appropriate care for an oncology patient was to communicate with the patient and their relatives and that working at the palliative care unit increased their approach to empathy. In studies on this subject, the ability to communicate effectively with patients and families was found to be an important skill for any palliative care nurse (Monterosso et al., 2016), and it was reported that good communication based on trust and respect helped patients to express their deep feelings, helped them find meaning in life, alleviate their suffering, and accept their situation (Dimoula et al., 2019; Yaşar et al., 2020). In a qualitative study conducted with palliative care nurses, the participants stated that good and trust-based communication with patients was very important. They explained that it was very difficult to share negative news with patients about their illness and that they used not only verbal but sometimes non-verbal communication methods to create a good communication environment during this process (Mishelmovich et al., 2016). Nurses, who are able to structure and maintain correct and effective communication with patients, are able to move on to a process that includes spiritual satisfaction as their experience increases, after they start coping effectively and learn to act more professionally (Dimoula et al., 2019; Yaşar et al., 2020).

Whereas the nurses defined providing moral support to patients and maintaining a sense of hope as one of their care

responsibilities in our study, they mostly described the inadequacy of physical environmental conditions and communication problems as being the challenges in relieving the pain and suffering of patients. In one study, it was determined that the most severe problems for patients receiving palliative care were pain, fatigue, and loss of appetite (Uysal et al., 2015). Presently, nurses try to provide optimum palliative and end-of-life care by meeting the physical, emotional, cultural, and spiritual needs of the persons involved and their family (Farfán-Zúñiga & Jaman-Mewes, 2021). In addition, especially cancer patients in palliative care may experience unbearable pain at the end of their lives. According to our study findings, nurses take steps to meet the self-care needs, to manage pain, to care for the wounds, and also meet the psychological support needs of palliative care patients. The present study revealed that nurses took initiatives for mutual nursing care. These nursing care practices, which are reflected in the individual care plan, are at the core of providing quality care and dignity in life until death. Similarly, the results of studies conducted in this context are similar to the findings (Temelli and Cerit, 2021).

Nurses participating in the study stated that another difficulty they encountered were the problems arising from the participation of families in patient care. The involvement of families is important to the patient and has always been central to personal, individualized care. Nurses, however, recommend providing individualized, effective palliative care to the patient. During care, various communication problems may arise between patients and nurses. Communication and collaboration with families can be central to achieving high-quality care, communicating with patients, and achieving good patient outcomes (Brent et al., 2018).

The functional and physical structure of palliative care centers should be such that patients can receive medical, psychological, social, and spiritual care. In our study, nurses expressed the inadequacy of social areas as problems affecting the quality of care. In studies which had similar findings as ours, nurses working at the palliative unit stated challenges in communicating, inadequate material and physical conditions, and an excess of workload as the difficulties they experienced while caring for patients (Kiyak et al., 2022). These practical challenges may reduce the quality of care provided to the patient. To achieve these goals, long-term financial planning is required for countries that are in the early stages of palliative care development (Uzelli et al., 2021).

In the study, nurses stated that when they encountered challenges in general, they mostly shared their feelings and thoughts with their team members and came up with solutions together. This result emphasized the effectiveness of collaboration between professionals in supporting quality patient palliative and end-of-life care outcomes (Soikkeli-Jalonen et al., 2020). The diversity arising from palliative care requirements necessitates professional teamwork in the field of care. The role of the team in the context of palliative care is explained in the literature, particularly by emphasizing the importance of team meetings and the existence of a safe environment in which concerns, doubts, and emotions can be expressed (Rehnsfeldt, 2005). Working in a supportive team can positively affect individual

members by strengthening interpersonal relationships through sharing experiences, responsibilities, and concerns.

In our study, the participants stated that providing continuous vocational training is effective in coping with difficulties. Similarly, in a study conducted by Uzelli et al. (2021), nurses stated that they attended trainings to individually improve themselves as a result of the challenges and problems they encountered and emphasized that regular in-service training should be provided to nurses for effective palliative care. It has been determined that the lack of knowledge of nurses about palliative care affects the quality of care (Andersson et al., 2016) and that there is a significant change in the knowledge, attitudes, and behaviors on palliative care of nurses working at the oncology unit after training is provided (Harden et al., 2017). In a study conducted by Carvajal et al. (2019), it was pointed out that nurses working in end-of-life care settings should have various knowledge and skills, such as meeting the physical, emotional, cultural, and spiritual needs of the person and their family (Carvajal et al., 2019). With this understanding, having nurses who reflect on professional development can be perceived as a force. Palliative care education should be comprehensively integrated into undergraduate and graduate education and should be supported by post-graduate in-service training. Other points suggested by nurses for effective palliative care in the study were clinical expertise, clinical protocols for the standardization of care, and the improvement of the physical environment at the clinic.

Study Limitations

This study has certain limitations. The research sample is limited to nurses working at the palliative service of a public hospital. Nurses who agreed to participate in the study were included. Another limitation is that qualitative research conducted in a phenomenological pattern does not yield clear and generalizable results due to its nature. However, examples, explanations, and life experiences which produce results that help to better describe and understand an event are shown. Therefore, the limitation of this study is that it cannot be generalized.

Conclusion and Recommendations

In this study, the experiences and practices of nurses in palliative and end-of-life care settings were examined. In this context, 6 main themes and 18 subthemes emerged. As a result of this study, nurses experienced difficulties in providing care to palliative, end-of-life, and dying patients. On the other hand, it has been determined that nurses had various learning outcomes and that their coping skills were team cohesion and continuous professional training. The results of this study may offer insight for a better understanding of the experience and practice in palliative and end-of-life care settings of nurses. Future research should focus on the experiences of nurses in the context of palliative home care, and interventions should be developed that focus on reducing burnout, not only for those working in palliative care but also for those working in other departments and who regularly come in contact with pain and death.

Ethics Committee Approval: Ethical approvals required for the study were taken from University Scientific Research and Publication Ethics Board (Date: 01.11.2022, Number: E-18457941-050.99-68824).

Informed Consent: Written informed consent was obtained from nurses who participated in this study.

Peer-review: Externally peer-reviewed.

Author Contributions: Concept - S.D.S., S.Ç.Ö., Y.K.; Design - S.D.S., S.Ç.Ö., Y.K.; Supervision - S.D., S.Ç.Ö., Y.K.; Materials - S.D.S., D.G., S.Ç.Ö., Y.K.; Data Collection and/or Processing - S.D.S., D.G., S.Ç.Ö.; Analysis and/or Interpretation - S.D.S., D.G., S.Ç.Ö., Y.K.; Literature Review - S.D.S., D.G., S.Ç.Ö., Y.K.; Writing - S.D.S., S.Ç.Ö., Y.K.; Critical Review - S.D.S., S.Ç.Ö., Y.K.

Declaration of Interests: The authors have no conflict of interest to declare.

Funding: The authors declared that this study has received no financial support.

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