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A Phenomenological Analysis of Experiences and Practices of Nurses Providing Palliative and End of Life Care

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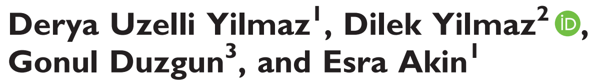

Abstract

The aim of this study was to describe the experiences and practices of nurses providing palliative and end of life care. The study was conducted in the palliative care unit of a territory hospital in Turkey. The sample consisted of 11 nurses who had been working as palliative care nurses for at least one year. The face to face interview method was used to collect data, with a semi-structured in-depth individual interview. 5 main themes and 24 sub-themes were emerged in relation to the experiences and practices of the nurses. The majority of participant nurses pointed that inadequacy in the number of nurses, secondary nursing care activities, refusal of treatment, cultural and ethical problems were barriers in the provision of nursing care. They frequently experienced ethical issues when caring for end of life patients, and for this reason they felt the need for ethics counselling which they could consult.

Keywords

palliative care, end of life care, nursing care, nursing practices, qualitative research

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Palliative care is a supportive approach which aims to increase the quality of life of patients and their relatives from diagnosis, through the progress of the disease to the mourning period after death (World Health Organization, 2020). The concept of palliative care comes under the framework of human rights, and everyone, irrespective of age, gender, religion, language, race or social security has the right to receive palliative care (Kahveci et al., 2017; Kim et al., 2015).

Today, more diseases are becoming chronic, and the World's aging population is increasing, bringing a greater need for palliative care, and health professionals are taking on important roles in the field of palliative and end of life care (Kahveci et al., 2017). Nurses, who are present at every stage of the illness, are important members of this team, and take part in all aspects of care from the moment of diagnosis to death, and in the mourning process after death (Schroeder & Lorenz, 2018). Nursing care in palliative care focuses on physical and spiritual comfort and aims relieve suffering, sufficient relief of distress and pain when a person receiving care is terminally ill or dying (Lindley et al., 2017; Valiee et al., 2012). Therefore, nurses have important responsibilities in providing care of palliative and end of life which conforms to clinical, cultural and ethical standards (Terzioğlu et al., 2015). Given this responsibility, nurses have many experiences relating not only to the physical aspects of nursing work, but also to the affective aspect, which includes emotions and professional and ethical values, and which provides direction for nursing practices (Pennbrant et al., 2015; Terzioğlu et al., 2015). Some studies highlight that working closely with terminally ill or dying patients can place a heavy burden on nurses. In a study with Turkish nurses caring for patients who were dying, it was found that the emotional responses given by nurses during the care process were sadness, hopelessness and anxiety (Cevik & Kav, 2013). In a recent study conducted with palliative care nurses by Temelli and Cerit (2019) found that the nurses felt good when the patient was given palliative care and when the positive communication was established, but they felt bad when the young patient was lost, and the patient was in pain. In a qualitative study by Hopkinson et al. (2003) with newly graduated nurses who were working in palliative care for the first time, it was shown that nurses felt guilt for the invasive procedures which they performed, and because of this they experienced disillusion. Although working with dying patients can be challenging, another study by Lopera (2015) found that nurses find caring for dying patients to be a rewarding and often life changing experience. Because the care process necessitates a close physical and psychological relationship between the nurse and the patient, nurses can see the most powerless and intimate aspects of patients, and they are frequently able to witness their pain and their feelings of loneliness and hopelessness. In this way, nurses may sometimes force to make difficult decisions regarding patients, and sometimes may unable to decide between two unsuitable alternatives and are faced with a dilemma (Özalp et al., 2017; Pennbrant et al., 2015; Terzioğlu et al., 2015). Therefore, nursing care in palliative care and end of life care are offered

to incorporate the individualized care into practices and deepen the awareness of patient needs and expectations (Lindley et al., 2017).

Palliative and end of life care are offered to improve physical, spiritual, and emotional needs of the patient and improve quality of life (Bodek, 2013; De Araújo et al., 2004; Iranmanesh et al., 2009). The effectiveness of high-quality palliative and end of life care largely depends on sensitive and timely nursing intervention (Fliedner et al., 2021). For instance, a study in a palliative care clinic, it was found that nurses' perception of care behaviors was high, and this was reflected on the quality of nursing care given in the clinic (Uzelli Yilmaz et al., 2017). Nurses' attitudes and actions of caring behaviours are influenced by their individual factors and subjective perceptions (Wilson, 2016). Moreover, their practices may vary depending on their previous experiences. With a thorough understanding of nurses' experiences and actions in the provision of palliative and end of life care will be a starting point for an effective change in the quality of care for this group of patients.

To better prepare nurses to deal with palliative and end of life care, it is important to first explain current nursing experiences and practices related to palliative and end of life care. Thus, nurses need to recognize and confront their own perceptions and attitudes toward care practices. Various studies have been made of palliative and end of life care in nursing, but there are only a few phenomenological qualitative research regarding the subject (Keane et al., 2020; Piredda et al., 2020).

This qualitative study set out to explore palliative and end-of-life care in palliative care unit and to fully demonstrate the experiences and practices of nurses on this subject. Thus, this study seeks to gain insight the phenomenon of the care practices by understanding the experiences and practices of nurses offering palliative and end of life care for patients and their families from their own perspective. This study sought to address one research question: What are nurses' experiences and practices of palliative and end of life care?

Methods

This study was conducted using the qualitative research method of phenomenological research design. Phenomenology is a qualitative research approach seeking an answer to the question "What is the meaning, structure and essence of events experienced for a particular person or persons?" (Lindseth & Norberg, 2004). Phenomenological research design was selected with the aim of describing nurses' experienced when providing palliative and end of life care, the meaning of providing palliative and end of life care.

In qualitative studies, individuals are chosen for interview on the grounds of whether they are directly related to the research topic, rather than for their power of representing the population. The most important indicator in selecting the study group in a phenomenological design is that it should be formed

from individuals who have experienced the phenomenon examined from all aspects (Palinkas et al., 2015). The study was conducted with 11 nurses with over a year's experience of working in the palliative care clinic of a territory hospital in Turkey between September 2017 and December 2017. The purposive sampling method was used in the study. The aim of the purposive sampling method is to determine a sample meeting certain criterion of importance which have been previously determined. The criterion for the sample was that nurses should have the experience of working for more than one year as palliative care nurse.

The data of the research were collected with a Nurses' Descriptive Form and a Semi-structured Interview Form.

Nurses' Descriptive Form: The descriptive form comprised questions on age, gender, education level, duration of professional work, duration of working in the unit, type of work, and the patient group to whom palliative and end of life care is provided.

Semi-structured Interview Form: The Semi-Structured Interview Form was created according to the aim of the research by the researchers and had eight questions. Semi-structured individual interviews were conducted using an interview guide.

Interview Questions

1. What does care mean to you for patients with palliative and end of life care?
2. What are the feelings you experience when giving palliative or end of life care to a patient?
3. What care practices do you implement as a palliative care nurse?
4. What do you think optimal care should be given to a patient receiving palliative or end-of-life care?
5. Have you had any feedback from patients or their families on the nursing care which you provide to patients? If you have, what does it mean to you?
6. What difficulties have you encountered when providing care?
7. How do you cope with the problems which you experience?
8. What would you recommend for more effective palliative and end of life care in palliative care units?

The data were collected through in-depth interviews in which the main research questions were asked. Prior to the interviews, all participants were contacted to ensure that previous arrangements were convenient and to ascertain their willingness to participate. All researchers took qualitative research courses during their graduate education. To improve the reliability and consistency of the data collection, the same researcher conducted all the interviews. The researcher who conducted the interviews had varying experiences as nurses and nurse managers in an emergency ward, and a palliative care clinic. Therefore, it was deemed that this researcher was capable of understanding

the participants' experiences and practices in the clinical setting. In addition, other researchers had recently published qualitative studies in journals.

Data were collected using audio-taped semi-structured interviews. The in-depth interviews were conducted with open questions that lasted between 45 and 60 minutes in a peaceful and quiet place in the palliative care unit. During the interview, the interviewer and the interviewees were seated at the same level and the participants actively listened to and were guided by the questions. Data collection was continued to a point at which subjects began to repeat themselves.

Data Analysis: The interview recordings obtained were written down in Microsoft Word format, and in analysis of the data, interpretive phenomenological analysis as recommended by Colaizzi (1978) was taken as a basis. The analysis stages used in Colaizzi's phenomenology studies are as follows: 1) recording a report; 2) showing the meaning of the explanations; 3) stating the meanings in a clear way; 4) arranging the explained meanings in the form of a theme cluster; 5) describing in detail: 6) explaining the basic structure of the case; 7) formulating the basic structure of the case. The documents were read word-by word several times by the researchers, this enabled a broad and general understanding of the content. During this step, sentences were scrutinized to meaningful statements. Then, the sentences and sentence structures in the data were encoded independently by scope of focus. All researchers identified themes and sub themes which were to represent these codes through iterative discussion until consensus emerged. Themes and sub-themes were integrated into a comprehensive description of the nurses' lived experiences of palliative and end of life care. All researchers independently identified themes, which were clarified through iterative discussion until consensus emerged. In presenting the findings relating to the themes, the researchers aimed to increase validity by including direct quotations from the views of the participants. Direct quotations were given in quotation marks.

Ethical Considerations

The researchers obtained ethical permission from the Palliative Care Clinic of Hospital (Reference Number: 11/17.08.2017) and from the nurses who agreed to participate in the research. All participants were given information orally about the study, and written informed consent was obtained from all participants. Ethical considerations of the research included obtaining the informed consent of the participants to participate in the study, recording their interviews anonymously and respecting the confidentiality of their transcriptions, personal secrets, and other related information. The participants were assured that they could leave the research at any stage.

Results

The mean age of the nurses was found to be 32.84 ± 3.12 years; 81.82% (n = 9) were female, 67.1% were university graduates, and 54.2% had previously worked in emergency or intensive care units. The nurses' mean length of time working in the profession was 11.14 ± 2.18 years, and 65.1% had been working in the palliative care clinic for 1–5 years. The nurses were working for 62.14 ± 12.55 hours a week. The patients to whom the nurses had most provided care was those with cancer (74.5%), morbid obesity (16.7%), chronic obstructive pulmonary disease (5.9%), and multiple sclerosis (2.9%).

Following the analysis of the data, the expressions made by the participants during the interviews were grouped under 5 main themes and 24 sub-themes of responses were determined (Table 1). Participants are shown as "P" following each sub-theme according to the order of interview.

Theme 1: Responsibilities in Providing Care

Some of the participants stated that nurses had responsibilities to patient advocacy (n = 4) or to leadership roles (n = 2), while others pointed that nurses had had responsibilities to maintain the feeling of hope for end of life care patients to the very last moment (n = 2), and to provide spiritual (n = 4) support to patients. 4 Sub themes were grouped under the Theme 1 according to responses of participants (Table 1).

Theme 2: Nursing Care Practices

The nurses reported that they mostly carried out practices of self-care needs (n = 8), on pain management (n = 7), on wound care (n = 6) and to meet nutritional needs (n = 4). 4 Sub themes were grouped under the Theme 2 according to responses of participants (Table 1).

Theme 3: Nursing Care Barriers

Most of the nurses (n = 10) thought that the inadequate number of nurses was a barrier to the provision of nursing care. On the other hand, some of the nurses stated that organizational procedures which they thought to be unnecessary reduced the time which nurses gave to care. Some nurses thought that patients' refusal of treatments (n = 4), cultural (n = 4) and ethical problems (n = 5), and problems which experienced with the participation of families in patient care (n = 4) were barriers in the provision of nursing care. 7 Sub themes were grouped under the Theme 3 according to responses of participants (Table 1).

Table 1. Description of Themes and Sub-Themes.

Themes	Sub-themes	Example codes
Responsibilities in providing care	Patient advocacy (P1, P3, P9, P10)	*"In certain decisions which are taken for palliative care patients, patients' families and sometimes other health professionals do not feel it necessary to take the views of the patient. Here, we taking patients' wishes into account, telling them about situations they aren't aware of, making them feel independent . . . This is an important responsibility."*
	Leadership (P2, P7)	*"With nursing care, we have responsibilities like supporting patients and their relatives in managing their own care and increasing their adaptation to the disease and their adherence to treatment. In achieving this, we affect not only the patient but also the team."*
	Maintaining a feeling of hope (P8, P10)	*"Patients, particularly in their last days, are unwilling to accept some treatments or procedures because of anxiety about death and become very unhappy. Here, as nurses we must maintain the feeling of hope in the patient to their last moment. In this way, patients feel better and not given up from their life."*
	Providing spiritual support (P4, P5, P6, P11)	*"In palliative care, we have a lot of patients experiencing spiritual anxiety. This creates a feeling of hopelessness. Of course, they don't want to talk about it. Because of this, we have the responsibility to give time and support them spiritually."*
Nursing care practices	Supporting self-care (P1, P2, P3, P4, P5, P9, P10, P11)	*"In palliative care, patients have difficulties in taking care of themselves, so there are self-care practices which we perform as routine. oral care, hair care, eye care, bed baths, and catheter care"*
	Pain management (P2, P3, P5, P8, P9, P10, P11)	*"Our patients are in a lot of pain. Also, routine procedures like positioning patients can cause the patients pain. So, we assess patients' pain before and after each procedure. We mostly use pharmacological treatments."*
	Wound care (P1, P2, P4, P5, P6, P10)	*"When patients develop pressure ulcers, we carry out daily wound care. In this, we work together with wound care nurses. In order for pressure ulcers not to form, we pay attention to changing the patient's position regularly, and carry out daily risk assessments."*
		"Patients generally have no appetite and their oral intake is inadequate. This brings many problems.

(continued)

Table 1. Continued.

Themes	Sub-themes	Example codes
	Supporting nutritional needs (P1, P3, P9, P10)	*So, we perform nutritional support by the oral way, and try to select tastes which the patients will like. When patients are in the end of life stage, we start to the parenteral way."*
Nursing care barriers	Inadequacy in the number of nurses (P1, P2, P3, P4, P5, P6, P7, P8, P9, P11)	*"The inadequate number of nurses in relation to the number of patients hinders us from providing care equally to each patient. We're making a greater effort, but we can't achieve the quality that we want."*
	Secondary nursing care activities (P2, P3, P5, P6, P9, P10)	*"Organizational activities such as checking patients and their families going in and out, answering the telephone and following up doctor orders are things we often have to do, and which take a lot of our time. This reduces the time we have to care for patients."*
	Defensive medical approach (P3, P4, P5, P9)	*"Something is not right. I see that some treatments are carried out because of a fear of an accusation of malpractice. Because many procedures are carried out unnecessarily, there may be no time left for other patients who may be in a worse condition."*
	Refusal of treatment (P2, P4, P7, P11)	*"Patients come to palliative care after a long and difficult treatment process. Here, they refuse some care and treatment procedures. On the one hand these things must be done, and on the other the patient's autonomy must be preserved. This is difficult for me when I'm providing care."*
	Cultural issues (P3, P6, P7, P8)	*"We provide to care for many patients from different cultures. We may have difficulties communicating. This is something which hinders care..."*
	Ethical issues (P2, P5, P7, P8, P11)	*"Particularly with interventional procedures, the patient sometimes resists. I can see that the patient has a pain and doesn't want this procedure. I feel very sorry for these patients, I am in dilemma. Which is right: not to continue with the procedure or to ignore the suffering?"*
	Family participation in nursing care (P3, P7, P8, P10)	*"We allow the patient's families to take part in care giving. Some families may misunderstand this. You change the sheets, you position the patient, but after you go out, they do something different."*
Experience of coping with difficulties	Health-care team support (P2, P4, P5, P7, P8, P11)	*"Team support is very important for coping with the difficulties that I've had. We work in a very good team. When I shared what I've experienced with*

(continued)

Table 1. Continued.

Themes	Sub-themes	Example codes
		another friend, she said she'd had the same experiences. It gives you a path to a solution. Thinking I'm not alone makes me feel good."
	Continuing professional development (P1, P3, P6, P9, P10)	*"Palliative care nursing requires experience and clinical expertise. I may be faced with many situations that I don't know about. Because of this, I take part in congresses, courses and training to acquire new knowledge and new skills."*
Views on effective palliative care	Experience and clinical expertise in palliative care (P1, P3, P4, P7, P8, P9, P10, P11)	*"Because palliative and end of life care is a special field, doctors and nurses working there should have had specialist training in order to be able to provide effective patient care or have had experience working in the field. This is because as doctors and nurses, we don't have the ability to evaluate the patient socially, psychologically, spiritually and acceptance processes all at the same time."*
	Increasing the number of nurses (P2, P3, P5, P7, P8, P9)	*"The number of nurses is very important for the quality of care. We work very hard and we have to provide effective care many patients. When there are too few nurses, patients who are in a bad situation may leave us no time for the others. The number of nurses should be increased for effective and equal care."*
	Individualized care (P4, P5, P8, P11)	*"All the care procedures we perform here should be specific to the patient. In order to increase the quality of palliative care, nursing care should be planned to take into account the needs of the patients and their families, their cultural background and their wishes. For example, we only have one chance to get it right for people who are dying, which is why their specific needs to be a much greater focus on meeting people's end of life wishes."*
	Clinic protocols (P1, P3, P7)	*"In palliative care, we're caring for a large number of chronic patients at different stages. We have our routines, but each nurse acts according to his or her own knowledge and skills. If there are care protocols which include up to date information and guidance, we can achieve a standard in care. This must be done for effective care."*
	Ethical counselling (P3, P5, P6)	*"Ethical problems encountered in palliative care affect the quality of care. On this topic, our knowledge is limited. There are times when we are faced with a*

(continued)

Table 1. Continued.

Themes	Sub-themes	Example codes
		dilemma. Things like the patient wanting to be discharged but the relatives not wanting it, Do Not Resuscitate (DNR) problems, religious and cultural issues or conflicts on the need for treatment procedures. There needs to be a consultant to advise us on problems like this which leave us in a dilemma."
	Physical environment in clinic (P1, P2, P5, P10, P11)	*"In palliative and end of life care, the patient's comfort is a priority, so I would like them all to have private rooms. This is also important for privacy during care. But at the same time hobby rooms could be set up for patients. Or else, patients spend all day in their beds. Areas could be set up for patients and those receiving radiotherapy or chemotherapy to occupy their time."*
	Regularly in-service training (P4, P8, P10)	*"There should be regular in-service training. Palliative care clinics are new in Turkey, and so a nurse starting work in the clinic who has only just heard the word 'palliative' cannot be expected to provide palliative care. Or there may be procedures that we don't know about. Especially for communication when giving bad news or in the process of bereavement, there needs to be organization in the hospital to increase nursing training."*

Theme 4: Experience of Coping With Difficulties

Some of the nurses stated that they received support from other members of the team when they had difficulties in giving palliative care (n = 6). Some nurses said they participate improve themselves by participating in training and courses on palliative care when they had difficulties in giving palliative care (n = 6). 2 Sub themes were grouped under the Theme 4 according to responses of participants (Table 1).

Theme 5: Views on Effective Palliative Care

Regarding the nurses' thoughts on effective palliative care, they emphasized the need for a professional team to provide care (n = 8), the need to increase the number of nurses (n = 6), the need for nursing care to be planned individually (n = 4), the need for clinical protocols in palliative care (n = 3), and the need for units where ethical counselling can be obtained (n = 3). Nurses point that improvement of physical conditions (n = 5), and for regular in-service training

to be given to nurses (n = 3). 7 Sub themes were grouped under the Theme 5 according to responses of participants (Table 1).

Discussion

A trend towards an increase in the number of autonomous roles for nurses and the degree of autonomy in their roles is important for the quality and functionality of the care given (Hall & Doran, 2004). Nurses today meet the physical, emotional, cultural, and spiritual needs of the person and their family work in delivering optimal palliative and end-of-life care (Ronaldson et al., 2012). Thus, the nurses in our sample emphasized that as well as roles such as patient's advocacy and leadership in palliative and end of life care, they also had responsibilities in maintaining a feeling of hope by supporting patients psychologically and spiritually. Nurses also recognized the importance of spiritual care as an essential part of providing death, dying, and palliative care.

Particularly when they are nearing the end of their lives, factors such as patients' general condition, a long stay in hospital or restriction of movement may cause shortcomings in the practice of hygiene. They may be unable to take food orally, and lack of movement causing pressure on parts of their bodies may result in pressure injuries. In addition, especially cancer patients in palliative care may experience an unbearable degree of pain at the end of their lives. According to the findings of our research, nurses act to meet the self-care needs of palliative care patients, to manage pain, to prevent injuries and to care for wounds, and also to meet patients' nutritional requirements. The current study revealed that nurses made ventures for common nursing care. These nursing care practices reflected in the individual care plan are inherent to providing quality care and dignity in life until death. Likewise, the results of studies in this context are similar to the findings (Goddard et al., 2013; Standing et al., 2017; Temelli & Cerit, 2019).

The nurses pointed that they faced various difficulties, barriers and challenges in the course of caring for palliative care patients, and they gave recommendations for effective palliative care. Among the difficulties experienced when caring for palliative care or end of life care patients was that the number of nurses was inadequate. They emphasized that the shortage of nurses affected the quality of nursing care, and reduced the time given to the care of patients. Thus, among the recommendations for effective palliative care was an increase in the number of nurses. Similar results were found in the other studies on the topic (Akin Korhan et al., 2018; Brooks et al., 2017; Garner et al., 2013). Fernando and Hughes (2019) highlighted that as the number of nurses caring the patient increases the likelihood that patients are achieving an effective palliative approach and/or palliative care manner. Therefore, there is a need to recognize the optimal the number of nurses in order to promote effective palliative and end of life care by managers and health organizations. The effective and

productive use of nursing manpower directly affects the quality of the service provided and the productivity of the hospital. In a study by Turkmen and Uslu (2011) reported that 16% of the time of nurses on the day shift was given to direct care procedures concerning the patients, and 15% to clinic-related duties. The nurses in our study stated that indirect care activities such as procuring drugs and equipment, checking the admission and discharge of patients or following up orders affected the time they gave to care activities. Another thing which was seen as hindering care giving was the performance of various examinations and practices by other health professionals which nurses saw as unnecessary. Some nurses stated that this was because health professionals were aiming to protect themselves from accusations of malpractice by ordering more diagnostic prosedures than were necessary. These kinds of defensive medical practices are mentioned in the literature, and are an important factor today affecting costs and patient care (Agarwal et al., 2019).

The nurses in this study clearly identified cultural problems as one of the difficulties in palliative and end of life care. Individuals from many different cultures live in Turkey and that the cultural diversity has become more different with the increasing number of immigrants and refugees in recent years. Nurses stated that communicating with patients and their families who are culturally different than their patients difficult toward implementing care and treatment in the palliative care unit. Language differences as well as cultural differences were found as barrier in the implementing care and treatment as well as cultural differences. Nurses pointed that the differences among the patients related to attitudes about death were also observed. This problem was documented in previous Turkish studies (Ardic et al., 2019; Sevinç, 2018). This is crucial to the notion of cultural competence in nursing, particularly for nurses working in culturally diverse areas. Among the difficulties in the palliative and end of life care was refusal of treatment. One of the nurses described a patient who refused treatment and wanted to return home and die peacefully there. Because the patient had expressed that these painful care and treatment procedures prolonged the death process. It was seen that the attitude and perception of individuals about life, death, and making decisions were affected their implementing palliative and end of life care. This may be seen as barrier to implementing care and can put nurses into the dilemma of whether to carry out treatment or to maintain the patient's autonomy. In this way, the nurses emphasized that ethical issues encountered in palliative care found as barrier and said that there was a need for an ethics committee and leaders for counselling to deal with ethical problems encountered in palliative and end of life care. This understanding ensures including appropriate referrals will be undertaken to alleviate such ethical issues.

The nurses participating in the study stated that another difficulty which they faced was the problems caused by the involvement of families in the patient's care. The involvement of families is important to the patient, and has always

been central in person-centered, individualized care. On the other hand, the nurses recommended that individualized care to the patient should be given in the provision of effective palliative care. During care, various communication problems can arise between patients and nurses. Communication and collaboration with families can be central to achieving high-quality care, communicate with patients and good patient outcomes (Brent et al., 2018).

In the study, nurses generally stated that when faced with difficulties, they mostly share their feelings and opinion with the team members and resolve solutions together. Healthcare providers working in palliative care setting cope with many challenges such as communication, decision-making, care planning, ethical issues, and spiritual/cultural sensitivity. Working in a supporting team can positively influence individual members through reinforcing interpersonal relationships with sharing of experiences, responsibilities and worries (Price et al., 2019). This result highlighted the effectiveness of interprofessional collaboration in promotion of quality patient palliative and end of life care outcomes (Babiker et al., 2014).

The nurses stated that they took part in training to develop themselves individually because of the difficulties and problems which they faced, and emphasized that for effective palliative care, regular in-service training should be given to nurses. Similarly, in a study by Andersson et al. (2016) to determine the palliative care practices of nurses with more than two years of experience, it was found that nurses prepared for necessary care behaviors by reading and obtaining information from medical records in order to be ready for frequently encountered situations and symptoms. A recently published scoping review by Carvajal et al. (2019) pointed that nurses who work in end of life care settings must have the various knowledge and skills needed, such as providing the physical, emotional, cultural and spiritual needs of the person and their family. With this notion, having nurses with considering professional development can be perceived a strength. Other points recommended by the nurses in the study for effective palliative care were a clinical expertise, clinical protocols for standardization in care, and improvement of physical environment in clinic. In order to achieve these objectives, it is necessary to plan long-term funding for countries in the early stages of the development of palliative care.

Limitations

Qualitative research conducted as a phenomenological design by its nature does not produce clear and generalizable results. However, examples, explanations and life experiences are shown, producing results which help to better describe and understand a case. For this reason, the limitation of this research is its inability to be generalized.

Conclusions

This study explored of nurses' unique experiences and practices in the palliative and end of life care settings. In this regard 5 main themes and 24 sub-themes emerged. In conclusion of the current study, it was revealed that nurses performed the practices for self-care needs, prevention of pressure injuries, pain relief and the maintenance of nutrition. Nurses have experienced difficulties in providing care to palliative, end of life and dying patients and their family members. Difficulties have included concerns about caring and communication with culturally diverse patients, refusal of treatment, healthcare team approaches and concerns about family participation in nursing care. On the other hand, the nurses seem to face challenges in the providing care due to a lack of expert guidance on ethical issues and an insufficient number of nurses working in the clinic. Nurse training programs include the effect of cultural influences on care, decision making on ethical problems, improving communication between families and healthcare team can help nurses cope with the problems. This study outcomes may be offer insight a better understanding of the experience and practices of nurses in the palliative and end of life care setting. Nurse training programs include the effect of cultural influences on care, decision making on ethical problems, improving communication between families and healthcare team can help nurses cope with the problems.

Authors' Note

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Authors' Contribution

Study conception and design: D. U. Y.; data collection: D. U. Y., G. D.; data analysis and interpretation: D. U. Y. and D. Y.; drafting of the article: D. U. Y., D. Y., and G. D.; and critical revision of the article: D. Y. and E. A.

Declaration of Conflicting Interests

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