

A qualitative study on oncology nurses' experiences of providing palliative care in the acute care setting

Proceedings of Singapore Healthcare
2017, Vol. 26(1) 17–25
© The Author(s) 2016
Reprints and permissions:
sagepub.co.uk/journalsPermissions.nav
DOI: 10.1177/2010105816660322
journals.sagepub.com/home/psh


Pei Fen Chuah¹, Mei Ling Lim¹, Seow Ling Choo¹, Guan Yi Woo¹,
Hiu Kwan To¹, Keat Yeng Lau¹, Juan Chen¹ and Siew Bee Lian²

Abstract

Background: With the renewed emphasis on palliative care in Singapore, coupled with a dearth of studies on provision of palliative care in acute services, it is timely to explore the experiences, barriers and challenges faced by oncology nurses in the acute care setting.

Aim: This study aimed to explore nurses' experiences of providing palliative care in the acute oncology care unit.

Method: An exploratory descriptive research methodology was adopted. Focus group interviews, involving a total of 24 nurses, were conducted. Interviews were audio-taped and transcribed verbatim. Data was analyzed using an inductive content analysis approach.

Results: Five key themes emerged from the analysis: (1) nurses' perceptions of palliative care; (2) multiple roles of nurses in palliative care; (3) emotional burden of providing palliative care; (4) misconceptions of palliative care; (5) challenges in providing palliative care.

Conclusion: The provision of palliative care in the acute care setting remained challenging. This is partly due to the attitudes of patients, families and healthcare workers, as well as organizational factors such as lack of training. Nurses play an important role in giving and facilitating palliative care for patients in the hospitals. Future studies can explore interventions to help overcome the challenges that are impeding nurses from providing high-quality palliative care in the acute care setting.

Keywords

Palliative care, oncology nurses, experiences, acute care, challenges

Introduction

Palliative care in Singapore and the acute care setting

The World Health Organization defined palliative care as

an approach that improves the quality of life of patients and their families facing the problem associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual.¹

Palliative care helps patients meet their needs during the final stages of their lives, alleviates suffering and maximizes their quality of life.² Singapore's rapidly aging population and increasing incidence of cancer and chronic illnesses is naturally leading to an increased demand for

palliative care.³ The Ministry of Health in Singapore is also working towards providing high-quality palliative care in the local setting by developing palliative care services across all care sectors in Singapore and using evidence-based guidelines to provide holistic care for patients.⁴ Palliative care services for patients are usually initiated from the acute care sector. Hence, it is important to look at the delivery of palliative care in the acute care settings

¹Singapore General Hospital, Singapore

²National Cancer Centre Singapore, Singapore

Corresponding author:

Mei Ling Lim, Singapore General Hospital, Bowyers Block B Level 2,
31 Third Hospital Avenue, 168753, Singapore.

Email: lim.mei.ling@sgh.com.sg



to ensure that patients receive the best palliative care right from the start.

Experiences of providing palliative care

Most of the published studies on health care professionals' experiences of palliative care have focused on the emotional wellbeing of specialist care team members. Palliative care nurses in an academic hospital tend to inhibit their emotions and adopt a rational attitude in palliative care, to avoid triggering emotional attachment when caring for the patients.⁵ In the first local study on the experiences of palliative homecare nurses in Singapore, it was revealed that the palliative homecare nurses generally had a positive experience caring for the dying as they were able to demonstrate the true meaning of caring and connect in depth with the small number of patients under their care. However, participants described a sense of powerlessness and frustrations when they were unable to initiate treatment during their home visits, especially when they were new to the job and there were no designated doctors assigned to the team.⁶

The delivery of palliative care in the local acute care setting involves both specialist palliative care teams and the general medical teams. The current approach in Singapore's health care system is to ensure that all new health care professionals possess basic knowledge in palliative care.⁷ Most acute care-admitted patients may be receiving palliative care from the general medical team in which the physicians have basic training in palliative care. However, Rodriguez et al.⁸ suggested that a specialist palliative care system (including specialist physicians) may provide better quality of care for these patients, as such a team is trained in providing the specialized care required. A recent study by Phua et al.⁹ concluded that there were infrequent discussions with patients on end-of-life decisions, and excessive burdensome interventions with inadequate palliative care for the dying in the acute care setting where there was no palliative care specialist. Although there have been some studies conducted on palliative care in Singapore,^{5,6,9} there is still a lack of local studies which focus on the experience of nurses providing palliative care in the acute care setting.

Background

Challenges of providing palliative care in an acute care setting

In recent years, health care institutions in Singapore have been employing more foreign nurses due to a shortage of nurses.¹⁰ The number of foreign nurses in Singapore has increased from 26% in 2012 to 29% in 2014.¹¹ The challenge of providing effective palliative care in the acute care setting is intensified due to differences in language, culture and practice as our nursing force is becoming increasingly diversified.⁵

End-of-life discussions are especially challenging for health care professionals in an increasingly diverse society, with the involvement of emotional and interpersonal issues.¹² Western cultures tend to emphasize more on autonomy, whereas Asian cultures believe that communities and families, not

individuals alone, are affected by life-threatening illnesses and the accompanying medical decisions. Asians value beneficence by encouraging hope even in the presence of terminal illness. Although guidelines on patient-centered communication in palliative care are available, there are limited studies focusing on exploring whether a multicultural society poses additional challenges for foreign nurses.

Studies have also shown that health care professionals faced difficulties communicating end-of-life issues with patients and their families.¹³⁻¹⁷ Inadequate communication often results in less satisfactory care, as many patients and families preferred health care providers to be more forthcoming in initiating end-of-life discussions and in assisting them to make suitable choices in planning of care.^{14,15}

Oncology nurses play an important role in communicating end-of-life issues with patients and families. These conversations take time, and often multiple communication sessions are required.¹³ Nurses are deemed to be in an ideal position to communicate end-of-life issues with patients and families on account of the higher attending rate and more extensive contact time with them.¹⁶ In addition, nurses were deemed able to translate patients' experiences and the language of medicine into something that the patients and their families can understand. This interpretive role of the nurse is key in ensuring that all decisions are consistent with patients' and families' values and goals.¹³ However, it is unclear whether local oncology nurses had managed to adopt such a role in a busy acute care setting.

Thus, it is important to explore the challenges faced by oncology nurses when having end-of-life discussions with patients and families, as it could potentially impede effective palliative care.

Aim

This study aimed to explore nurses' experiences of providing palliative care in the acute oncology care unit.

Method

An exploratory descriptive methodology was adopted.¹⁷ This method allowed us to gain an insight and understand nurses' experience in their own right.

Sampling

Purposive sampling was used. Participants recruited were registered nurses with at least 6 months of working experience in an oncology or hematology ward and had prior experience in providing palliative care. Nurses in managerial or nurse clinician roles, agency nurses, part-time nurses, student nurses and nurses on permanent night shift were excluded as they had differing roles (as compared with registered nurses) with regards to delivery of palliative care.

Data collection

Focus group interviews were conducted. Focus groups were used as this method encourages a greater degree of

spontaneity of responses and views; participants may feel supported and empowered by a sense of cohesiveness and hence express more views and opinions.¹⁸ The focus group interviews were semi-structured to elicit information from the participants. An interview guide was developed after reviewing the literature on provision of palliative care by nurses.¹⁹ The interview guide covered areas such as the nurses' perception and the benefits of palliative care, their experiences in providing palliative care, the challenges they faced when providing palliative care, and their suggestions for improvements in palliative care.

A total of four focus group interviews were conducted by the investigator, with six study participants in each focus group. Another team member was also present to act as a moderator and to record the non-verbal cues of the participants. The participants consisted of mixed groups of junior and senior nurses. The interviews were conducted in a private room within an inpatient medical oncology ward. Each session lasted approximately 1 hour. Basic demographic data of the participants was also obtained. All interviews were audiotape-recorded, and field notes were taken on non-verbal cues displayed by the participants during the interviews. In order to increase credibility and dependability of data, all interviews begin with this key question: What is your perception of palliative care? Probes were used to clarify the meaning of responses and to help participants to elaborate on their comments.

Data analysis

The audiotape recordings of the focus group interviews were transcribed verbatim. Non-verbal expressions were also included in the transcripts. The transcripts were verified against the audiotape recordings by two independent research team members.

An inductive content analysis approach was used to analyze the data. This involved open coding, creating categories and abstraction. In open coding, notes and headings were written in the transcript while reading it. The transcript was then read through again, and notes written down to describe all aspects of the content. Higher-order headings were then grouped into categories by comparing data that belong to a particular group and other notes that do not. During abstraction, a general description of the categories was formulated.²⁰ To ensure confirmability, the whole study team read through all the transcripts, came up with themes independently and explored areas where a consensus could not be reached.

Ethical consideration

Ethical approval was obtained from the SingHealth Centralised Institutional Review Board. Written informed consent from all participants was obtained prior to the interviews.

Results

The participants' years of working experience ranged from less than 3 years to more than 12 years. Their ethnicities include Chinese ($n=12$), Malay ($n=5$), Indian ($n=2$), Burmese ($n=3$), Filipino ($n=1$) and Nepalese ($n=1$). Among the 24

Table 1. Summary of participants' demographics.

Demographics	Participants (n=24)
Gender	
Female	23
Male	1
Ethnicity	
Chinese	12
Malay	5
Burmese	3
Indian	2
Filipino	1
Nepalese	1
Years of working experience	
Less than or equal to 3 years	9
3.1–6 years	5
6.1–9 years	3
9.1–12 years	1
12 years and more	6
Nationality	
Singaporean	15
Permanent resident	5
Others	4
Religion	
Free thinker	9
Islam	5
Buddhism	4
Hinduism	3
Christianity	2
Catholics	1
Highest qualification obtained	
Diploma in Nursing	10
Advanced Diploma	5
Bachelors in Nursing	5
Certificate in Nursing	1
Bachelors in Nursing (Honours)	3

participants, one was a male nurse. Participants had different religions but majority of them were free thinkers ($n=9$). A summary of the participants' demographics (age, gender, ethnicity, religion, and nationality), years of working experience and highest qualifications obtained is presented in Table 1.

Five main themes were identified: (1) nurses' perceptions of palliative care; (2) multiple roles of nurses in palliative care; (3) emotional burden of providing palliative care; (4) misconceptions of palliative care; and (5) challenges in providing palliative care. Themes and sub-themes are illustrated in Table 2.

Theme 1: Nurses' perceptions of palliative care

The nurses perceived palliative care to encompass addressing patients' physical and emotional needs. Nurses reported the need for personalized care and how comfort is prioritized in palliative care. Nurses also spoke of the need to care for the family, especially in terms of providing information and emotional support.

Subtheme 1: Individualized care. Palliative care was deemed as providing individualized care that catered to the specific needs

Table 2. Summary of themes and sub-themes.

Themes	Sub-themes
Nurses' perceptions of palliative care	<ul style="list-style-type: none"> • Individualized care • Comfort care • Emotional support
Multiple roles of nurses in palliative care	<ul style="list-style-type: none"> • Care for the family • Advocate • The intermediary • Companion
Emotional burden of providing palliative care	<ul style="list-style-type: none"> • Helplessness • Sad • Guilt • Bereavement
Misconceptions of palliative care by other healthcare professionals	<ul style="list-style-type: none"> • Palliative care equates to hastening death • Palliative care is giving up hope
Challenges in providing palliative care	<ul style="list-style-type: none"> • Ambiguity in roles • Lack of understanding on goals of palliative care by families. Language and culture barriers • Unconducive environment and low nurse-to-patient ratio • Skills and knowledge deficit

of the patients. Besides the patient, this care was also often extended to the caregivers and family.

It's an individual care for patient. Different patients have different needs, ... then also is for the families ... [P5]

Very individualized ... because every patient is different. They way each of them faced, faced this or the families you know, towards palliative care is really really different. [P2]

Subtheme 2: Comfort care. More specifically, palliative care was commonly associated with rendering comfort care to reduce the suffering of the patients and ensure maximum possible quality of life.

... like making dying patient as comfortable as possible. [P3]

Give them more comfortable to, (pause) to don't let them suffer too much. [P7]

Okay for myself I feel that palliative care is more about ensuring the quality of their end of life is at the best. So let's say if they have pain or what we will try to manage that. And just basically to make them comfortable. Yah for their last days. [P18]

Subtheme 3: Emotional support. Besides comfort care, providing emotional support was also perceived as palliative care. The nurses indicated that emotional support is essential to guide patients who are anxious and worried about their condition.

Basically what makes me feel is that you are just helping the patient and the family to go through the, that very hard process it is not an easy process (...) Helping them to like accept, helping them to go through the difficult moments. Ya, they just sometimes just need not only to treat but actually to be there to listen, to give the support because some of them doesn't have a very good family support. So we are here to actually act as a family to let them go through the difficult process. [P5]

Subtheme 4: Care for the family. Palliative care was also described to encompass care for the patient's family. Helping family members to cope and providing them with relevant information and emotional support were viewed as a part of palliative care.

Emotional support for the family when the patient is already ill. So ya, not only for the medical part, but psychosocial part also we are playing a big part of it. [P5]

Mmm, help them in step down, emotional support and maybe ask their family anything that you all need us to help out before discharging them or what. [P21]

Oh I think palliative is more on helping both patients and family on their coping mechanisms, looking at ways on how they can cope better with their illnesses and their prognosis... [P17]

Theme 2: Multiple roles of nurses in palliative care

Nurses viewed themselves adopting different roles when rendering palliative care. Upholding the rights of patients, coordinating care and spending time with the patients were the three main roles identified by the nurses in this study.

Subtheme 1: Advocate. Nurses acted as advocates for patients, ensuring that the decisions made are always in the patients' interests.

Actually there is one case in transplant side the patient relapse and then the doctor actually wants to wait for the counts to recover and then try a salvage chemo but ... the patient actually verbalized that he is very tired already and don't want to go for further chemotherapy and wants to go home and wait to die ... during the round we did try to tell the doctors, that's what the patient wish to do ... So in the end the patient I think got his wish ... he went home and died after that. [P12]

Subtheme 2: The intermediary. Some patients may require step-down care such as hospice, or choose to go home to die. The nurses helped by acting as the intermediary to assist the patients and family members cope with this care transition from the acute care hospital setting back to the community or home. Besides transition care, nurses were often seen going beyond their clinical roles to facilitate patients' special requests.

Actually palliative patient to me what I saw is either they are very very ill or for some is because their old age and they are not going for, very much, very invasive chemo ah, treatment so I think it depends on the situation you have to prepare them to step down, maybe to hospice, or go home with a hospice care association with them. I think is more of middle person also? [P21]

'Hmm (pause) in addition to resource we're also say the middleman lah. If they (patient) want to get what they want, we try means to get it. Like for example some of the patients they actually request to see their family one last time. They'll (nurse) try to get the doctor to write... Let's say there's someone in the prison right, they'll try to get the doctor to write up a memo, to release the prisoner for just a short moment to visit the family member. [P6]

Subtheme 3: Companion. The nurses also played the role of companion for patients and the caregivers to make them feel less lonely in their journey of care; they acted as a "familiar face" or even as their "family" in times of need. Nurses felt that their presence can mean a lot for patients or caregivers who are in distress.

So by having ourselves be with them I think we are just helping actually a small portion. Helping them to like accept, helping them to go through the difficult moments. Ya, they just sometimes just need not only to treat but actually to be there to listen, to give the support because some of them doesn't have a very good family support. So we are here to actually act as a family to let them go through the difficult process. [P5]

Theme 3: Emotional burden of providing palliative care

The nurses experienced a myriad of emotions when caring for terminally ill patients. Feelings of sadness, helplessness, guilt and difficulty with letting go were emotions felt by the nurses during their care for these patients. Some nurses indicated that they found it hard to cope with such negative feelings at times.

Subtheme 1: Helplessness. Some nurses felt powerless when they did not know how to help patients who are dying. They witnessed display of sadness but felt that they could not render any help to make their patients feel better.

Because seeing them like very sad but you don't know what to say to them ... Something like that. They keep crying and you don't know how you can help them. Ya just look at them helplessly. [P12]

Subtheme 2: Sad. The nurses experienced sadness as they witness changes in their patients' physiological and physical conditions. They felt it was unjust when their patients were young and had their lives cut short by illnesses.

... some of the young boy and girl, is to, be on palliative care because they are so young but then, still got, for the normal people, still got long life to go through right, but they are already under palliative care, so that make me very sad. ... Some patient err (pause), become very swollen, edematous and then is not, totally not look like themselves. Is a lot of changes, this also make me feel very sad for them. [P7]

Subtheme 3: Guilt. The nurses felt a sense of duty to be able to actively intervene and felt guilt-ridden when they were unable to help patients and families reconcile their differences.

Sometime they (patients) can just shut down themselves then they don't be happy. That's what if the patient shut down, they will make more problem for the family members because they feel sad if the patient don't talk, until they die also they don't talk. Then the family would have all the guilt and we also will feel the guilt. [P5]

Subtheme 4: Bereavement. The nurses placed a high value on their relationships with patients and recounted that it is an integral component of palliative care. When patients die, nurses grieve as well, and they sometimes found it hard to cope with the bereavement process.

... the nurses delivering the palliative care have to know themselves how to detach because when you are giving the palliative care, you are giving err, err, so called a closed care for the patient. So sometime if our emotionally is too close with the patient and family, hard. Sometime some nurses find this very hard to detach themselves so by giving palliative care, sometime emotionally for the nurses need to be quite strong. [P5]

It always depends on who the patient is I would say. More on, how much you know also plays a part because sometimes the more you get to know about a patient, the harder it gets to let go. [P18]

Theme 4: Misconceptions of palliative care by other health care professionals

The nurses thought that other health care professionals did not fully understand the indications of palliative care, and might not be adequately trained to provide comfort care. This led to differences in opinions during the provision of comfort care. Difference in opinions made it more difficult for nurses to advocate for palliative patients who needed the appropriate care. Nurses felt that the wrong type of care was provided for their patients.

Subtheme 1: Palliative care equates to hastening death. Health care professionals were portrayed as holding misconceptions about palliative care. Symptom control such as ensuring adequate pain relief was equated with hastening death. Health care professionals were found to be less receptive towards palliative care when they had not received adequate training on palliative care.

...patients already taking pain killers and it doesn't work so breathless at the same time and then I just suggested instead of giving bolus pushes of morphine and all that, why can't you just give a continuous infusion, a low dose. So the first remark they (doctors) say is like, you want to kill the patient is it? [P24]

Actually I think the oncology doctors also need to be taught. Because sometimes even when you broach the subject to them, or you suggest only, not all are receptive. When I said morphine only, some of them

like "no, no", all the way no. I can't even convince the doctors, what more the junior one? [P19]

Subtheme 2: Palliative care is giving up hope. In other instances, palliative care was associated with giving up on the patient, a notion which was unfamiliar and unacceptable to some junior doctors.

... sometimes we have on-call doctors or those very new doctors, which they're really, they're unaware of what palliative means. So there are times when your patient is dying and all you want to do is to keep them comfortable. Maybe they feel kind of strange like how come I'm just letting a person go by not doing anything, so which they'll run more tests and run more examinations on the patients ... [P14]

Theme 5: Challenges in providing palliative care

Although palliative care is becoming increasingly common in the inpatient acute care setting, the nurses still faced multiple challenges such as difficulty in initiating palliative care for patients, language and cultural differences and conflicting expectations from families. Some nurses also indicated that the low nurse-to-patient ratio and lack of knowledge prevented them from providing good palliative care.

Subtheme 1: Ambiguity in role. Initiation of palliative care was challenging when the patient's prognosis was not disclosed to either the patient or the family members.

... there are landmines we can't be stepping on. Sometimes the family doesn't want the patient to know what their own diagnosis or prognosis is, and at times it'll be that the patient doesn't want us to tell the family either. So sometimes we don't know what information we can relay, what information we can't relay. This becomes a bit of a constraint ... if we can actually relay this better to them, I'm sure we can actually come up with a better management for their terminal plans. [P18]

Some nurses felt that doctors have to initiate palliative care first before they can step in to play their role in providing palliative care.

Well I think this one the doctor has to first decide that they gonna put it in the palliative category. I mean as nurses I don't think so we have that thing at all. I think you know, you should let go and go into palliative. I think once the doctor has decided that oh this patient is for prognosis is poor palliative comfort care, then maybe we can go in and say that, but we also have to know how much they know. Suddenly the doctor never say then we go there and talk is no point ... [P4]

Subtheme 2: Lack of understanding on goals of palliative care by families. The families (of patients) did not understand the meaning of palliative care and often have expectations that were not in line with the palliative teams' management plans. They thought that the health care professionals were not caring and were heartless when seen not providing active interventions.

... those patient with terminal agitation right, so we will sedate them so sometimes they will say "why you sedate them, can you

make them wake up?" But they don't understand that if now they wake up, they, this patient would not be comfort, which is the aim of palliative. So, they don't understand, sometimes it is a bit hard to breakthrough to them. Because they think like "Oh you are just keeping her quiet so you all don't have to care about her or something". It's not that. [P1]

But I know patient is very in the, towards the end stage right, they are very edematous or what, then we were saying oh it is not, it, it not good to give too much fluids then they are thinking "oh you are not treating". This kind of thoughts a bit difficult, challenging for us to go through. [P6]

At times, the nurses' professional judgement may differ from the families' expectations when caring for the patient. Conflicting values made palliative nursing more challenging and added to nurses' dilemmas and frustration while providing care.

... They (family) keep on like every five minutes, can you imagine, ordering fentanyl every five minutes to purge, every five minutes, five minutes. I don't know how, I cannot understand how fast they want to like let go of the father. I think like when we told them that the patient is very comfortable and he is not having any pain, in fact he is sleeping soundly, they still want us to purge ... I feel stucked ... we try to explain to the relative like, the doctor's order is that they will only give the fentanyl if he is suffering in pain. But they are "no no no, we want him to be very comfortable." Is like we cannot win them, just give just give like that ... So when the next morning, when the doctor came, he asked how come you keep on purging, is he really in pain? Because it always come back to us (...) Of course the father will die like that ... because it is for us, I'm really against doing all these things. When you are like, you see the patient are very comfortable. [P20]

Subtheme 3: Language, cultural and ethnic barriers. Language and cultural differences hindered nurses in rendering good palliative care to patients. The foreign nurses in particular indicated how language and cultural differences deter them from providing good palliative care for the patients.

Yes basically the same problem is the language barrier because we want to do then, we want to do something for them, they just say oh no I don't understand you, ask a Chinese lady to help. So when you want to help, you're being blocked because we do not know how to communicate with them. [P11]

Mmm, ya I think sometimes when you want to, like, err, give comfort to the, relative, you don't know how to say about? Right, there's cultural difference. (...) like sometimes you want to say something but they take it in another perspective? [P8]

In cases where nurses shared the same ethnicity with the patients, they found it easier to build rapport and communicate with them.

Because if she my ethnic and I can talk to her, we tend to talk more about other things like family members and how many family members I have, we tend to talk more and then we tend to be closer to them rather than other patients if ethnic, of other ethnic groups. So let's say if they pass away, we do still, um, the empathy is much more than other, because we have, um, actually have a very good bond with them already. [P11]

Subtheme 4: Unconducive environment and low nurse-to-patient ratio. Acute care settings were thought to be unconducive for providing palliative care due to the patients' mix and acuity. Nurses found switching between caring for acute medical and palliative patients challenging.

Because in hospitals, the care, the environment, I guess is not very, is not very suitable for them (...) there's a lot of different kinds of patients in the hospital... I think we need a lot of time to care for the palliative patient... [P12]

Sometimes we have to switch gears because we'll have this active management on going for one patient, then palliative come, I need to change drugs for one patient. So you just have to prioritize la (...) You can no way juggle both at one go, unless you have a very good team then yeah you can do that. [P17]

Time and manpower were not enough to care for palliative patients as the nurses still need to nurse other patients with acute conditions.

It's more of tired because sometimes there's not much manpower and then it's only you and your "junior" having to take care of them with other patients. Sometimes you will feel as though you never give much to the patient because you don't know when are they dying. So like, um, you said you want to but end up, they already go and then you didn't had the time to actually talk to them la, because we are also stressed with other things. [P11]

Subtheme 5: Skills and knowledge deficit. The lack of knowledge in palliative care created fear and feelings of uncertainty in nurses when they approached terminally ill patients. They felt incompetent in their therapeutic communications with their patients. This was most evident in nurses who had just graduated, where they were lost and unsure about managing palliative patients.

... how am I supposed to tell him in a nicer way so that he won't feel that we're giving his life up? Because it's very direct, you tell him his days are numbered, you tell him he's going to die. So actually I was very scared, because you have to be so careful with your words. Because if you say anything wrong, the patient may get the wrong impression and that's it already. So although we would love but I think better brush up our skills first. [P14]

For me when I newly grad that time, I don't even dare to look at all those dying patients. It's kind of fear because I don't know what's happening. I don't know what they're giving, I don't know what will happen to the patient if I touch the patient... [P15]

I think there is a lot of thing we need to be improved. Because we seldom have palliative under hematology. Most of them is the oncology patients, and if it is hemato patient is always very old patient already so we short of knowledge about palliative care also la. [P7]

They (junior nurses) have no knowledge. Ya, very lack of knowledge, very lack of skill. [P21]

Discussion

The nurses in this study perceived palliative care as individualized care, maximizing comfort for the patient, providing emotional

support and caring for the family. This is in consonance with the fundamental concepts of palliative care which encompass personalized care and family support.²¹ Likewise, providing comfort was described by nurses as a holistic approach that is synonymous with individualized care.²²

The nurses played multiple roles in palliative care and this was consistent with previous findings. Advocating, coordinating, mobilizing resources and caring were identified by a group of oncology nurses who were interviewed for their perspectives of nursing roles in palliative care.²³ Similarly, the nurses in this study viewed themselves as advocates of patients, or an intermediary to coordinate resources and provide care and companionship to the patients. These roles are also in line with the World Health Organization's definition of palliative care.

Palliative nursing has been associated with causing stress and emotional burden for nurses. The nurses in this study faced emotions such as helplessness, sadness and guilt when caring for palliative patients. Evidently, the personal emotional investment in the nurse-patient relationship can lead to fatigue and stress for nurses.^{22,24} A recent literature review concluded that nurses experience a myriad of feelings when caring for dying patients in the acute care hospital setting. Nurses felt stressed, incompetent and impotent, and perceived a sense of inadequacy when nursing palliative patients in the hospital.²⁵ Likewise, stress was identified as a personal cost of nursing by a group of district nurses who provided palliative care to their community in the United Kingdom.²⁶ Emotional stress experienced by nurses in the workplace should not be ignored, as it will affect their overall health and work performance which, in turn, may impact on the quality of patient care.

Interestingly, many health care providers still hold misconceptions about palliative care. The nurses in this study indicated that they worked with physicians who misunderstood the meaning of palliative care and were reluctant to initiate palliative care for patients. Other studies have presented similar views where clinicians had reservations about initiating palliative care and transiting to an end-of-life focus.²⁷⁻³⁰ There is still a focus on acute and interventionist care in acute care settings, and this often contributed to a delayed referral of patients to palliative care. Feelings of failure have also been reported by physicians when they initiate palliative care for their patients in the hospital, even if this was introduced alongside active care.²⁹

Initiating palliative care in the acute care setting has always been challenging for nurses. Some nurses in this study felt that doctors still play a pivotal role in initiating palliative care in the hospital. This is consistent with the results of Csikai,¹⁴ where the need for palliative care was first mentioned to patients and caregivers by the physicians.¹⁴ Referral to palliative care is still much dependent on the doctors.⁸ Furthermore, a focus group interview with a group of health care professionals identified that the point of transition to palliative care in the acute care setting was often ambiguous, and even when the transition to palliative care did occur it was often delayed or near the time of death.²⁸ The fact that hospitals focus on acute medicine and have little discussion with the patients and families regarding the prognosis made the start of palliative care for patients challenging. In addition, nurses in this study at

times faced the dilemma of telling the truth, when either the patient or the caregiver refuse to disclose the diagnosis. This can contribute to ineffective delivery of palliative care. Honesty between health care providers and patients or the caregivers is deemed as essential to deliver the best care, as all stakeholders need to have the same goal in mind.²³

Disagreement between family members and the health care providers was another barrier highlighted by the nurses in this study. Expectation mismatch can lead to delay in palliative care for the patients. This is evident in Asian culture, where there is less emphasis on individualism and more on what the caregivers expect you to do on behalf of the patients.²⁴

Similarly, for nurses in this study, language and cultural differences act as a hindrance to nursing palliative patients. A big portion of the nursing workforce is made up of foreign nurses. Foreign nurses tended to have language barriers with the local patients.⁵ Given that Singapore is a multicultural society, communication issues involved in the nurse–patient interaction will be more complicated. Likewise, cultural differences resulted in nurses withholding communication with patients of a different religion for fear that they might offend the patients.⁵ Patients were also found to be less receptive in communicating with nurses of a different language and culture.³¹

The nurses in this study found it hard to care for both acute and palliative patients in the same setting, as their nursing needs differ greatly. In a recent review, the uncondusive hospital environment was highlighted as one of the challenges faced by patients dying in an acute care setting.³² Similarly, other studies have reported the lack of privacy for palliative patients and their families.^{25,33,34} The hospital environment, which encompasses the physical surroundings and the social interactions with hospital staff, can impact on the quality of palliative care experienced by patients.³⁵ Balancing the optimum physical environment for palliative care in a clinically focused hospital setting is tough. The acute care hospital is not designed for end-of-life care.³² Besides, the ability of nurses to provide optimal care for palliative patients in the acute care setting is limited by the heavy workload in the acute care ward; this in turn prohibits them from spending enough time with the terminally ill patients.²⁵ A qualitative interview conducted with 10 nurses in an acute care unit found that division of nursing time between patients of different acuities is difficult, hence it is even harder for them to spend additional time with palliative patients who naturally require more attention and nursing time.³³ This is consistent with the encounters by nurses in this study, where they experienced difficulties in switching care between the two extreme groups of patients and felt that they were not devoting enough care time for their palliative patients.

Inadequate skills and knowledge in palliative care were reported by nurses in this study. This is a common finding in other studies, where general nurses perceived themselves as undertrained for managing patients with palliative needs.^{24,36,37} When nurses are not given the necessary training in palliative care, they were reported to be less confident in discussing sensitive topics such as death and prognosis with patients and caregivers.³⁶ Likewise, nurses indicated the need for palliative

training to help them provide optimal care for patients.²² Emphasis was placed on providing communication training tailored to the acute care hospital setting.^{28,24}

Limitations

The findings of this study were interpreted by our researchers based on this specific group of nurses during this period of time. Therefore, our findings cannot be generalized to other populations or contexts. Also, group dynamics within focus groups may have hindered junior nurses from sharing their experiences among more senior colleagues.

Conclusion

This study highlighted nurses' experiences in providing palliative care in the acute care setting in Singapore. Nurses play a huge part in providing emotional and psychosocial support both to patients and families. The acute care sector is still considered inappropriate and under-prepared for palliation, and the hospital environment itself is not suited to holistic palliative care. The provision of palliative care services in Singapore is still very much inhibited due to the attitude towards palliative care shown by patients, families and health care workers. This highlights the numerous challenges that the provision of palliative care in the acute care sector in Singapore still faces. Future studies can look at interventions to help overcome these challenges that are impeding nurses from providing high-quality palliative care in the acute care setting. It will also be worthwhile to explore the views and experiences of other health care providers and identify the knowledge gaps and challenges of initiating palliative care in the inpatient environment.

Declaration of conflicting interests

None declared.

Funding

The study is funded by SGH Research Grant.

References

1. World Health Organization. WHO Definition of Palliative Care [Internet]. Geneva: World Health Organization, <http://www.who.int/cancer/palliative/definition/en/> (2012, accessed 28 January 2016).
2. Rome R, Luminais H, Bourgeois D, et al. The role of palliative care at the end of life. *Ochsner J* 2011; 11: 348–352.
3. Standards Development Subgroup of the National Strategy for Palliative Care Implementation Taskforce. *National Guidelines for Palliative Care*. Singapore: Standards Development Subgroup of the National Strategy for Palliative Care Implementation Taskforce, 2015.
4. Gan KY. Speech by Mr Gan Kim Yong, Minister for Health, at Singapore Palliative Care Conference at Singapore Polytechnic Convention Centre, 28 June 2014 [Internet]. Singapore: Ministry of Health, https://www.moh.gov.sg/content/moh_web/home/pressRoom/speeches_d/2014/speech-by-mr-gan-kim-yong-minister-for-health-at-singapore-pal.html (28 June 2014, accessed 28 January 2016).

5. Tay LH, Ang E and Hegney D. Nurses' perceptions of the barriers in effective communication with inpatient cancer adults in Singapore. *J Clin Nurs* 2012; 21: 2647–2658.
6. Chong PH and Poon WH. The lived experiences of palliative home-care nurses in Singapore. *Singapore Med J* 2011; 52: 151–157.
7. Lien Centre for Palliative Care. Report on national strategy for palliative care. Singapore: Lien Centre for Palliative Care, 2011.
8. Rodriguez KL, Barnato AE and Arnold RM. Perceptions and utilization of palliative care services in acute care hospitals. *J Palliat Med* 2007; 10: 99–110.
9. Phua J, Kee ACL, Tan A, et al. End-of-life care in the general wards of a Singaporean hospital: An Asian perspective. *J Palliat Med* 2011; 14: 1296–1301.
10. Khalik S. Singapore faces nurse shortfall for years to come. *The Straits Times*, 15 February 2013, Sect. A:1.
11. Singapore Nursing Board. *Annual Report 2014*. Singapore: Singapore Nursing Board, 2015.
12. Searight HR and Gafford J. Cultural diversity at the end of life: Issues and guidelines for family physicians. *Am Fam Physician* 2005; 71: 515–522.
13. Bushinski RL and Cummings KM. Practices of effective end-of-life communication between nurses and patients/families in two care settings. *Creat Nurs* 2007; 13: 9–12.
14. Csikai E. Bereaved hospice caregivers' perceptions of the end-of-life care communication process and the involvement of health care professionals. *J Palliat Med* 2006; 9: 1300–1309.
15. Parker SM, Clayton JM, Hancock K, et al. A systematic review of prognostic/end-of-life communication with adults in the advanced stages of a life-limiting illness: Patient/caregiver preferences for the content, style, and timing of information. *J Pain Symptom Manage* 2007; 34: 81–93.
16. Boyd D, Merkh K, Rutledge DN, et al. Nurses' perceptions and experiences with end-of-life communication and care. *Oncol Nurs Forum* 2011; 38: 229–237.
17. Sandelowski M. Whatever happened to qualitative description? *Res Nurs Health* 2000; 23: 334–340.
18. Sim J. Collecting and analysing qualitative data: Issues raised by the focus group. *J Adv Nurs* 1998; 28: 345–352.
19. Elliott R and Timulak L. Descriptive and interpretive approaches to qualitative research. In: Miles J and Gilbert P (eds) *A handbook of research methods for clinical and health psychology*. Oxford: Oxford University Press, 2005. pp.147–159.
20. Elo S and Kyngas H. The qualitative content analysis process. *J Adv Nurs* 2008; 62: 107–115.
21. Meghani SH. A concept analysis of palliative care in the United States. *J Adv Nurs* 2003; 46: 152–161.
22. Roche-Fahy V and Dowling M. Providing comfort to patients in their palliative care trajectory – experiences of female nurses working in an acute setting. *Int J Palliat Nurs* 2009; 15: 134–141.
23. Pavlish Cand Ceronisky L. Oncology nurses' perceptions of nursing roles and professional attributes in palliative care. *Clin J Oncol Nurs* 2009; 13: 404–412.
24. Beng TS, Chin LE, Guan NC, et al. The experiences of stress of palliative care providers in Malaysia: A thematic analysis. *Am J Hosp Palliat Care* 2015; 32: 15–28.
25. McCourt R, Power J and Glackin M. General nurses experiences of end-of-life care in the acute hospital setting: A literature review. *Int J Palliat Nurs* 2013; 19: 510–516.
26. Dunne K, Sullivan K and Kernohan G. Palliative care for patients with cancer: District nurses' experiences. *J Adv Nurs* 2005; 50: 372–380.
27. Bloomer MJ, Moss C and Cross WM. End-of-life care in acute hospitals: An integrative literature review. *Am J Health Syst Pharm* 2011; 3: 165–173.
28. Gott M, Ingleton C, Bennett MI, et al. Transitions to palliative care in acute hospitals in England: Qualitative study. *BMJ Support Palliat Care* 2011; 1: 42–48.
29. Gardiner C, Cobb M, Gott M, et al. Barriers to providing palliative care for older people in acute hospitals. *Age Aging* 2011; 40: 233–238.
30. Bloomer M, Endacott R, O'Connor M, et al. The 'dis-ease' of dying: Challenges in nursing care of the dying in the acute hospital setting. A qualitative observational study. *Palliat Med* 2013; 27: 757–764.
31. Haddad A. Acute care decisions. Ethics in action – Fairness, respect, and foreign nurses. *RN J* 2002; 65: 25–28.
32. Al-Qurainy R, Collis E and Feuer D. Dying in an acute hospital setting: The challenges and solutions. *Int J Clin Pract* 2009; 63: 508–515.
33. Thompson G, McClement S and Daeninck P. Nurses' perceptions of quality end-of-life care on an acute medical ward. *J Adv Nurs* 2006; 53: 169–177.
34. Gardiner C, Brereton L, Gott M, et al. Exploring health professionals' views regarding the optimum physical environment for palliative and end of life care in the acute hospital setting: A qualitative study. *BMJ Support Palliat Care* 2011; 1: 162–166.
35. Robinson J, Gott M, Gardiner C, et al. The impact of the environment on palliative care patient experiences of hospital admissions in palliative care. *BMJ Support Palliat Care* 2015; 0: 1–8.
36. Ingleton C, Gardiner C, Seymour JE, et al. Exploring education and training needs among the palliative care workforce. *BMJ Support Palliat Care* 2013; 3: 207–212.
37. Weigel C, Parker G, Fanning L, et al. Apprehension among hospital nurses providing end-of-life care. *J Hosp Palliat Nurs* 2007; 9: 86–91.