Challenges Faced by Nurses Working in Palliative Care Centers*

Palyatif Bakım Merkezlerinde Çalışan Hemşirelerin Karşılaştığı Zorluklar*

Araştırma Research

Sibel Özdemir Özmen[1], Alev Yıldırım Keskin[2]

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Abstract

Objective: This study was conducted to determine the difficulties experienced by nurses working in palliative care centers.

Methods: Data were collected using the descriptive "Personal and Professional Introductory Information Form" prepared by the researcher and the "Palliative Care Difficulties Scale (PCDS)". In the evaluation of the data; numbers, percentages and means, Independent t-test, One Way ANOVA test, Mann Whitney U test, Kruskal-Wallis test, Spearman Correlation test, and simple linear regression analysis test were used. The significance level of statistical tests was accepted as $p<0.05$.

Results: It was determined that 92.5% of the nurses participating in the study were women, 49.1% were between the ages of 31-40, 75.5% had a bachelor's degree, and 82.1% worked with palliative care patients for 0-5 years. The total mean score of nurses' PCDS was 42.82±7.69, sub-dimensions of the scale communication in multidisciplinary teams 8.60±2.38, communication with patient and family 9.44±2.29, expert support 7.44±2.35, the mean score of 44±2.35, reducing symptoms 8.83±2.55, and communication coordination sub-dimension was 8.50±2.59, which was above the medium level. It was determined that the nurses participating in the study considered the inconvenience of work environment conditions, excessive workload, mobbing, the inadequacy of corporate culture, inability to make one-to-one decisions, and physical, economic and socio-cultural factors as palliative care barriers. Nurses stated that they needed team communication and expert support in wound care, tracheostomy care, positioning, and respiratory support practices, and they had difficulties. It was determined that there was a significant difference between the PCDS total score and its sub-dimensions ($p<0.05$).

Conclusion: Nurses working in palliative care face many difficulties and it is thought that it is important to strengthen health services, and policies to remove these obstacles.

Keywords: palliative care; hospice and palliative care nursing; nursing care

Özet

Amaç: Bu çalışma, palyatif bakım merkezlerinde çalışan hemşirelerin yaşadıkları zorlukları belirlemek amacıyla yapılmıştır.

Yöntem: Veriler, araştırmacı tarafından hazırlanan tanımlayıcı veri toplama formu ve Palyatif Bakım Zorlukları Ölçeği (PBZÖ) kullanılarak toplanmıştır. Verilerin değerlendirilmesinde; sayı, yüzde ve ortalamalar, Independent t testi, One Way ANOVA testi, Mann Whitney U testi, Kruskal-Wallis testi, Spearman Korelasyon testi, basit doğrusal regresyon analiz testi kullanılmıştır. İstatistiksel testlerin anlamlılık düzeyi $p<0,05$ olarak kabul edilmiştir.

Bulgular: Çalışmaya katılan hemşirelerin %92,5'i kadın, %49,1'i 31-40 yaş arasında, %75,5'i lisans mezunu, %82,1'inin palyatif bakım hastalarıyla çalışma süresi 0-5 yıl olduğu belirlenmiştir. Hemşirelerin PBZÖ toplam puan ortalaması 42,82±7,69, ölçek alt boyutlarından "multidisipliner ekiplerde iletişim" 8,60±2.,38, "hasta ve aile ile iletişim" 9,44±2,29, "uzman desteği" 7,44±2,35, "belirtilerin azaltılması" 8,83±2,55 ve "iletişim koordinasyonu" alt boyutu puan ortalamaları 8,50±2,59 olarak orta düzeyin üzerinde bulunmuştur. Çalışmaya katılan hemşireler iş ortamı koşullarının uygunsuzluğunu, iş yükü fazlalığını, mobbingi, kurum kültürü yetersizliğini, birebir karar verememeyi, fiziksel, ekonomik ve sosyo kültürel etkenleri palyatif bakım engeli olarak gördükleri belirlenmiştir. PBZÖ toplam puanı ve alt boyutları arasında istatistiksel olarak anlamlı bir farklılığın olduğu saptanmıştır ($p<0,05$). Hemşireler, yara bakımı, trakeostomi bakımı, pozisyon verme ve solunum desteği uygulamalarında ekip iletişimi ve uzman desteğine ihtiyaç duyduklarını ve zorlandıklarını belirtmişlerdir.

Sonuç: Palyatif bakımda çalışan hemşireler birçok zorlukla karşılaşmakta ve yaşadıkları bu engellerin kaldırılmasına yönelik sağlık hizmetleri ve politikaların güçlendirilmesinin önemli olduğu düşünülmektedir.

Anahtar Sözcükler: palyatif bakım; hemşirelik; hemşirelik bakımı

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[1] *Milli Eğitim Bakanlığı Sultanbeyli Celal Gündoğdu Halk Eğitimi Merkezi, Sultanbeyli/İstanbul (Orcid no: 0000-0002-9099-527X)*
[2] *Doç. Dr., Selçuk Üniversitesi Akşehir Kadir Yallagöz Sağlık Yüksekokulu (Orcid no: 0000-0003-0981-5364)*

Introduction

Palliative care is defined by the World Health Organization (WHO) as care applied to alleviate symptoms and improve the life qualities of patients with severe and incurable diseases (1). Thanks to scientific advances in the healthcare field, sudden deaths due to diseases are decreasing, and the life expectancy of people with chronic and fatal diseases is extended with curative treatments. Thus, the prolongation of lifespan increases individuals' need for palliative care with each passing day (2). Every year, 40 million patients worldwide need palliative care, of which 7% (1.2 million) are children (3,4). 39% of people with diseases that require palliative care had cardiovascular diseases, 34% had cancer, 10% had Chronic Obstructive Pulmonary Disease (COPD), 6% had HIV/AIDS, and 5% had Diabetes Mellitus (DM) (4). While approximately 37.4% of the decedents need palliative care services, only less than 10% can access those services. In addition, both the decedents and their relatives are emotionally affected before and during their death. After the death of individuals, the palliative care process continues during the mourning period of their relatives (3). The increase in global chronic diseases, advanced age, difficulty in symptom control, holistic care needs (physiological, psychological, and sociological), and patient and family members' demands have made palliative care widespread (5). In meeting these increasing demands, health workers (from health care professionals to nurses) have serious responsibilities. Among these responsibilities, it is emphasized that nurses should have knowledge and experience about the palliative care system and increase their expertise (6).

No matter how experienced the nurses are in palliative care, caring for a fatal patient with a severe general condition is a stressful situation with various difficulties for nurses (7). When the studies conducted with nurses providing palliative care are examined, the difficulties experienced by nurses are as follows; lack of palliative care education (8), lack of communication between patient-patient relatives-team (9,10), insufficient specialist support, (11) lack of continuous palliative care education (9,10), emotional stress (11), emotional problems, weakness (7), feeling of inability to support patient relatives (10), compassion fatigue (11), hopelessness, anxiety (12), denegation, helplessness (10), lack of funding (9), legal difficulties in opioid use (8), difficulties in pain management due to uncertainties in opioid use (7,8), and lack of research (12).

It is stated that palliative care nurses can overcome the barriers (lack of knowledge, difficulty in coping with stress, communication problems, lack of personnel, lack of finance and policy, lack of awareness of the society about palliative care services, cultural and social barriers, incompatibility among healthcare professionals, barriers to accessing opioids) foreseen for their palliative care management, thanks to their knowledge of palliative care and their awareness of the difficulties that may be experienced (3,8,13,14). Discussing the palliative care challenges in nursing is essential to overcome unmet needs in the healthcare system. In this sense, nursing skills and the usability of nursing care can directly affect the safety, quality, and efficiency of the healthcare system (7,15). By identifying the difficulties that nurses face while giving palliative care, improving the working environment can contribute to the nursing care service and the quality of life of sick individuals. Also, palliative care nurses can guide the team members during the care process (3,14). Therefore, this study was conducted to determine the challenges faced by nurses working in palliative care centers.

Research Questions:

1. What are the challenges that nurses face in the palliative care process?
2. What are the factors affecting the challenges faced by nurses providing care in palliative care units?
3. What is the mean score of the Nurses' Palliative Care Difficulties Scale?

Methods

1. Study Design

This cross-sectional and descriptive study was conducted to determine the challenges faced by nurses working in palliative care centers.

2. Study Setting and Sample

The study population consists of nurses working in palliative care units of five different hospitals in Istanbul, between August 2021 and October 2021. It was planned to include a total of 116 palliative care nurses working in these hospitals

in the study, but due to the pandemic, only the units that continued to serve could be reached. Since there were nurses who did not want to participate in the study (5), who was on leave at the time the study was conducted (3), and who filled in the questionnaires incompletely (2), the study sample consisted of 106 (91.37%) nurses.

3. Data Collection

The questionnaire was applied to the nurses working in the palliative care units of five different hospitals in Istanbul and who met the inclusion criteria of the research" (i) working as a palliative care nurse, (ii) volunteering to participate in the research, (iii) filling out the data collection forms completely", through the link created online on google forms due to the Covid-19 pandemic measures. Through the data collection form, which includes an informed consent form explaining the purpose of the study and giving information, and a consent box stating their participation in the study, informed consent was obtained from the participating nurses. To increase the visibility of the data collection form link, repeated reminders were shared by the researcher on their e-mail addresses and WhatsApp groups once a week, considering that the nurses were working hard during the pandemic process.

4. Data Collection Tools

While collecting the data, the Personal and Professional Information Form which was prepared by the researcher in line with the literature (7,11,16-20), the Palliative Care Difficulties Scale (21), and the Informed Consent Form were used.

Nursing Identification Form: The personal and professional information form is fifteen questions. There are questions about nurses' socio-demographic characteristics, working hours, total working time with palliative care patients, in which unit they work, and their knowledge about palliative care.

Palliative Care Difficulties Scale: The scale was developed by Nakazawa et al. (2010) (22). In addition, the Turkish validity and reliability of the scale was made by Kudubes et al. (2019) (21). It consists of 15 items describing palliative care difficulties, and five sub-dimensions Communication in multidisciplinary teams (items 1-3), communication with the patient and family (items 4-6), expert support (items 7-9), reducing symptoms (items 10-12), and communication coordination (items 13-15). It is a five-point Likert-type scale and is responded as "1=Never, 5=Always". Minimum score of the total score of the PCDS: 15, maximum score: 75, for each of the sub-dimensions of the scale, communication in multidisciplinary teams, communication with the patient and family, expert support sub-dimension, symptom reduction sub-dimension, communication coordination sub-dimension, minimum score: 3, maximum score: 15. An increase in the score obtained from the scale indicates that the difficulties faced by palliative caregivers increase. The Cronbach alpha value of the scale was found to be 0.81. Yet, for this study, it was determined as 0.79.

5. Ethical Considerations

Permission was obtained from the Non-Interventional Scientific Research Ethics Committee, Okan University (meeting decision number 120-10 dated 19.02.2020) to conduct the research and collect data. The online consent was taken from the participant nurses. Furthermore, this study was conducted under the Good Clinical Practice Principles of the Declaration of Helsinki.

6. Statistical Analysis

The data obtained from the data collection form was used with the SPSS for Windows 21.0 (IBM Statistical Package Social Sciences, Türkiye) program. The conformity of the variables to the normal distribution was evaluated with the Shapiro-Wilk test, Q-Q plots, and histograms. In data analysis, the number, percentage, minimum and maximum values, mean, and standard deviations were calculated. The Independent t-test was used to compare two independent groups in the analysis of normally distributed data, One-Way ANOVA to determine the difference between more than two independent groups, the Mann-Whitney U test for comparing two independent groups in the analysis of non-normally distributed data, and the Kruskal-Wallis test and Regression analysis to determine the difference between more than two independent groups. Spearman's rank correlation coefficient was used to determine the relationship between two quantitative variables. Significance was accepted as $p<0.05$.

Results

The results obtained in this cross-sectional and descriptive study to specify the palliative care challenges faced by nurses that are working in palliative care centers are summarized under the following headings. The sociodemographic characteristics of the nurses participating in the study were given in Table 1. Accordingly, 92.5% of the nurses participating in the study were women, the mean age was 32.96 years (min:22, max:56), 49.1% were 31-40 years old, 61.3% were married, 75.5% had a bachelor's degree, 67.9% had 1-10 years of work experience, 82.1% of them worked with palliative care patients around 0-5 years, 58.5% of them willingly chose the palliative care unit (Table 1).

Table 1. The distribution of nurses by sociodemographical characteristics. (N=106)

Variables	**Total (N=106)**	**%**
Age, years, mean (SD)	32.96 (6.80), range=22 - 56	
Age group		
Up to 30	37	34.9
31- 40 years	52	49.1
41 and above	17	16.0
Gender		
Female	98	92.5
Male	8	7.5
Marital status		
Single	34	32.1
Divorced	7	6.6
Married	65	61.3
Educational status		
High school	3	2.8
Associate degree	14	13.2
Bachelor's degree	80	75.5
Postgraduate	6	5.7
Doctorate	3	2.8
Work experience		
1-10 years	72	67.9
11- 20 years	21	19.8
21 years and above	13	12.3
Total working time with palliative care patients		
0-5 years	87	82.1
6-10 years	19	17.9
Status of voluntarily selecting the palliative care unit		
Yes	62	58.5
No	44	41.5
Total	106	100.0

The distribution of the palliative care characteristics of the nurses participating in the study is shown in Table 2. Of the nurses who participated in the research, 45.1% of them stated that they received in-service training on palliative care, 28.6% received information about the nursing process in palliative care, and 11.7% marked that they saw excessive workload as a palliative care barrier (Table 2).

Table 2. The distribution of nurses by their palliative care characteristics.

Characteristics	**n**	**%**
Way to learn about palliative care		
I took a palliative care course in my education process.	35	24.3
I attended to a course.	22	15.3
I attended to a congress.	22	15.3
I attended to in-service training.	65	45.1
Knowledge in palliative care		
Palliative Care Process	75	23.3
Nursing Process in Palliative Care	92	28.6
Information on Loss and Mourning Period of Palliative Care	61	18.9
Information on Symptoms that May Occur in Palliative Care	59	18.3
Information on Interactions to Make Patients Feel a Sense of Control	35	10.9
Barriers in providing palliative care		
Excessive workload	97	11.7
Insufficient number of caregivers/personnel	91	10.9
Insufficient corporate culture	39	4.7
Intra-team conflicts	31	3.7
Mobbing	42	5.0
Policies	31	3.7
Lack of education	45	5.4
Socio-cultural factors	44	5.3
Physical factors	46	5.5
Economic factors	34	4.1
Patient's refusal of treatment	27	3.2
Attitudes of patients' relatives	82	9.9
Difficulty in patient positioning	74	8.9
Psychological distress of patients	65	7.8
Insufficient materials	42	5.0
Inability to make one-on-one decisions	37	4.4
I did not encounter any difficulties.	5	0.6

* More than one option was marked and percentages were calculated over "n".

Table 3. Total mean score of nurses' PCDS and the average of sub-dimension score and Croncbach Alpha reliability coefficient.

		Avg.	Sd.	Min.	Maks.	α
Palliative Care Difficulties Scale Sub-dimension	Communication sub-dimension in multidisciplinary teams (Min: 3, Max: 15)	8.60	2.38	3	13	0.737
	Communication sub-dimension with patient and family (Min: 3, Max: 15)	9.44	2.29	3	14	0.736
	Expert Support sub-dimension (Min: 3, Max: 15)	7.44	2.35	3	14	0.687
	Reduction of symptoms sub-dimension (Min: 3, Max: 15)	8.83	2.55	3	15	0.765
	Communication coordination sub-dimension (Min: 3, Max: 15)	8.50	2.59	3	13	0.736
Total	(Min: 15, Max: 75)	42.82	7.69	22	61	0.796

Avg:Average, Min: Minimum, Max: Maximum, Sd: Standart deviation, α: Cronbach's Alpha.

The total score of the Palliative Care Difficulties Scale and sub-dimension mean score shown of the nurses participating in the research is given in Table 3. The total mean score of nurses' PCDS was 42.82±7.69, sub dimensions of the scale communication in multidisciplinary teams 8.60±2.38, communication with patient and family 9.44±2.29, expert support 7.44±2.35, the mean score of 44±2.35, reducing symptoms 8.83±2.55, and communication coordination sub-dimension was 8.50±2.59, which was above the medium level (Table 3).

The comparison of the Palliative Care Difficulties Scale (PCDS) and sub-dimension mean scores according to some characteristics of the nurses participating in the research is given in Table 4. In the study, it was found that the scores of male nurses' communication in multidisciplinary teams sub-dimension and single nurses' symptom reduction sub-dimension were significantly high ($p<0.05$). According to the research findings, it was found that the nurses who see excessive workload as a palliative care barrier had significantly higher scores in expert support, symptom reduction, coordination of communication sub-dimensions, and total scale averages ($p<0.05$). Also, nurses who see physical factors as palliative care barriers have significantly higher scores in reducing symptoms and coordination of communication sub-dimensions, and total scale averages ($p<0.05$). In addition, nurses who see sociocultural factors as palliative care barriers have significantly higher scores in symptom reduction sub-dimension and total scale averages ($p<0.05$). Nurses who see corporate culture inadequacy as a palliative care barrier had significantly higher total scale score averages ($p<0.05$). Nurses who see mobbing as a palliative care barrier have a significantly higher mean score of reducing symptoms sub-dimension ($p<0.05$). Furthermore, nurses who see the inability to make a one-to-one decision as a palliative care barrier have significantly higher scores in expert support, symptom reduction, and coordination of communication sub-dimensions, and total score averages ($p<0.05$). Moreover, nurses who see economic factors as palliative care barriers have significantly higher score averages in reducing symptoms and coordination of communication sub-dimensions ($p<0.05$). Nurses who performed wound care and positioning practices in palliative care had significantly lower score averages in communication in the multidisciplinary teams sub-dimension ($p<0.05$). Finally, nurses who performed respiratory support and tracheostomy care in palliative care had significantly higher score averages in the expert support sub-dimension ($p<0.05$) (Table 4).

Table 5 shows the results of the simple linear regression analysis using the total scores of the palliative care difficulties scale as the dependent variable. According to the findings, nurses who see the inability to make one-to-one decisions as a palliative care barrier have higher PCDS total scores than nurses who do not see it as a handicap ($p<0.05$). Nurses who see excessive

Table 4. The comparison of PCDS scores and sub-dimension mean scores according to some characteristics of nurses.

	Palliative Care Difficulties Scale					
	Communication in multidisciplinary teams Avg-Median (Min-Max)	Communication with the patient and family Avg-Median (Min-Max)	Expert support Avg-Median (Min-Max)	Reduction of symptoms Avg-Median (Min-Max)	Coordination of communication Avg-Median (Min-Max)	Total scale score Avg-Median (Min-Max)
Gender						
Female	8.46-9.0 (3-13)	9.40-9.0 (3-14)	7.36-7.0 (3-14)	8.77-8.0 (3-15)	8.42-8.0 (3-13)	42.44-42.0 (22-61)
Male	10.25-10.5 (8-12)	9.87-10.0 (8-12)	8.37-8.0 (6-11)	9.50-10.0 (5-12)	9.37-9.0 (7-12)	47.37-47.5 (40-54)
Statistical Value	**0.041[M]**	0.482[M]	0.128[M]	0.404[M]	0.324[M]	0.082[T]
Marital status						
Single	8.79-9.5 (4-13)	9.55-10.0 (3-13)	7.52-7.0 (4-13)	9.76-10.0 (6-15)	8.58-9.0 (3-12)	44.23-44.5 (26-61)
Divorced	9.14-10.0 (6-12)	10.28-10.0 (8-13)	8.71-8.0 (3-14)	8.71-8.0 (3-12)	10.14-12.0 (4-13)	47.0-53.0 (24-58)
Married	8.44-9.0 (3-12)	9.29-8.0 (5-14)	7.26-7.0 (3-12)	8.35-8.0 (3-15)	8.27-8.0 (3-13)	41.63-42.0 (22-55)
Statistical Value	0.662[K]	0.471[K]	0.437[K]	**0.037[K]**	0.183[K]	0.211[W]
Seeing excessive workload as a palliative care barrier						
Yes	8.62-9.0 (3-13)	9.49-9.0 (5-13)	7.60-7.0 (3-14)	9.00-9.0 (3-15)	8.71-9.0 (3-13)	43.44-43.00 (22-61)
No	8.33-8.0 (6-12)	8.88-8.0 (3-14)	5.66-6.0 (3-8)	7.00-6.0 (6-11)	6.22-6.0 (3-11)	36.11-36.00 (27-45)
Statistical Value	0.659[M]	0.594[M]	**0.022[M]**	**0.011[M]**	**0.009[M]**	**0.006[T]**
Seeing physical factors as a palliative care barrier						
Yes	8.91-10.0 (3-12)	9.63-9.5 (5-13)	7.80-7.5 (3-14)	9.58-10.0 (3-13)	9.41-10.0 (4-13)	45.34-45.0 (24-60)
No	8.36-9.0 (3-13)	9.30-8.0 (3-14)	7.16-6.5 (3-13)	8.25-8.0 (3-15)	7.80-7.5 (3-13)	40.88-41.5 (22-61)
Statistical Value	0.157[M]	0.402[M]	0.108[M]	**0.002[M]**	**0.002[M]**	**0.003[T]**
Seeing socio-cultural factors as a palliative care barrier						
Yes	8.63-9.0 (3-12)	9.72-9.5 (5-13)	7.70-8.0 (3-14)	9.47-10.0 (3-15)	9.06-10.0 (3-13)	44.61-45.0 (24-57)
No	8.58-9.0 (3-13)	9.24-9.0 (3-14)	7.25-7.0 (4-13)	8.37-8.0 (3-15)	8.09-8.0 (3-13)	41.54-42.0 (22-61)
Statistical Value	0.712[M]	0.314[M]	0.235[M]	**0.021[M]**	0.059[M]	**0.043[T]**

Seeing the inadequacy of corporate culture as a palliative care barrier						
Yes	9.02-10.0 (3-12)	9.33-9.00 (3-13)	7.92-7.0 (3-14)	9.41-10.0 (5-13)	9.07-9.0 (3-13)	44.76-43.0 (26-60)
No	8.35-8.0 (3-13)	9.50-9.0 (6-14)	7.16-7.0 (3-13)	8.49-8.0 (3-15)	8.16-8.0 (3-13)	41.68-42.0 (22-61)
Statistical Value	0.097[M]	0.925[M]	0.221[M]	0.056[M]	0.079[M]	**0.046[T]**
Seeing mobbing as a palliative care barrier						
Yes	8.73-9.0 (3-12)	9.45-9.0 (3-13)	7.81-7.5 (3-14)	9.47-9.5 (5-15)	9.07-9.0 (3-13)	44.54-44.0 (34-57)
No	8.51-9.0 (3-13)	9.43-9.0 (6-14)	7.20-7.0 (3-13)	8.40-8.0 (3-15)	8.12-8.0 (3-13)	41.68-42.0 (22-61)
Statistical Value	0.531[M]	0.825[M]	0.173[M]	**0.035[M]**	0.070[M]	0.061[T]
Seeing inability to make one-to-one decisions as a palliative care disability						
Yes	9.00-10.0 (3-12)	9.35-9.0 (5-13)	8.21-8.0 (5-14)	9.97-10.0 (6-15)	9.45-10.0 (3-13)	46.0-46.0 (26-60)
No	8.39-8.0 (3-13)	9.49-9.0 (3-14)	7.02-6.0 (3-13)	8.21-8.0 (3-15)	7.98-8.0 (3-13)	41.11-42.0 (22-61)
Statistical Value	0.116[M]	0.820[M]	**0.017[M]**	**<0.001[M]**	**0.005[M]**	**0.002[T]**
Seeing economic factors as palliative care barriers						
Yes	8.88-9.0 (3-13)	9.05-8.5 (3-13)	7.70-7.0 (4-14)	9.61-10.0 (6-13)	9.23-9.5 (3-13)	44.5-45.0 (26-61)
No	8.47-8.5 (3-12)	9.62-9.0 (6-14)	7.31-7.0 (3-13)	8.45-8.0 (3-15)	8.15-8.0 (3-13)	42.02-42.0 (22-60)
Statistical Value	0.303[M]	0.350[M]	0.322[M]	**0.022[M]**	**0.043[M]**	0.123[T]
Nurses' wound care and positioning practices in palliative care						
Yes	8.51-9.0 (3-13)	9.44-9.0 (3-14)	7.43-7.0 (3-14)	8.84-8.0 (3-15)	8.49-8.0 (3-13)	42.73-42.0 (22-61)
No	11.66-12.0 (11-12)	9.33-10.0 (8-10)	7.66-7.0 (6-10)	8.33-8.0 (7-10)	8.66-9.0 (6-11)	45.66-48.0 (38-51)
Statistical Value	**0.010[M]**	0.986[M]	0.802[M]	0.788[M]	0.957[M]	0.518[T]
Status of nurses to practice respiratory support and tracheostomy care in palliative care						
Yes	8.66-9.0 (3-13)	9.54-9.0 (3-14)	7.58-7.0 (3-14)	8.84-8.0 (3-15)	8.65-9.0 (3-13)	43.29-43.0 (22-61)
No	8.09-8.0 (6-11)	8.54-8.0 (6-12)	6.18-6.0 (4-11)	8.72-10.0 (6-12)	7.18-6.0 (3-12)	38.72-40.0 (27-48)
Statistical Value	0.368[M]	0.151[M]	**0.031[M]**	0.830[M]	0.099[M]	0.062[T]

Avg: Average, Min: Minimum, Max: Maximum, M: Mann-Whitney U test, K: Kruskal-Wallis H test, T: Independent Samples t-test, W: Welch's test.

Table 5. The linear regression analysis results of factors predicting palliative care difficulties scale measurement scores.

Variable	Coefficients	Beta	t	p	F	Model (p)	R^2
IMOD	Ref = [No]				10.590	0.002	0.092
	Yes	4.884	3.254	**0.002**			
	Stable	41.116	46.365	**<0.001**			
EXWL	Ref = [No]				7.974	0.006	0.071
	Yes	7.332	2.824	**0.006**			
	Stable	36.111	14.538	**<0.001**			
PF	Ref = [No]				9.471	0.003	0.075
	Yes	4.465	3.078	**0.003**			
	Stable	40.883	42.781	**<0.001**			
Mobbing	Ref = [No]				3.590	0.061	0.033
	Yes	2.860	1.895	0.061			
	Stable	41.688	43.870	**<0.001**			
ICC	Ref = [No]				4.072	0.046	0.038
	Yes	3.082	2.018	**0.046**			
	Stable	41.687	44.986	**<0.001**			
Gender	Ref = [Male]				3.091	0.081	0.029
	Female	-4.926	-1.758	0.082			
	Stable	47.375	17.586	**<0.001**			
Age	Ref=[30 years and over]				0.168	0.845	0.003
	31-40 years	-0.940	-0.563	0.574			
	41 years and over	-0.266	-0.117	0.907			
	Stable	43.324	33.974	**<0.001**			

IMOD: Inability to make one-on-one decisions, EXWL: Excessive workload, PF: Physical factors, ICC: Insufficient corporate culture, R^2: Coefficient of determination.

workload as a palliative care barrier have higher PCDS total scores than nurses who do not ($p<0.05$). In addition, nurses who see physical factors as palliative care barriers have higher PCDS total scores than nurses who do not see physical factors as barriers ($p<0.05$). Lastly, nurses who see the inadequacy of the corporate culture as a palliative care barrier had higher PCDS total scores than the nurses who did not ($p<0.05$) (Table 5).

Discussion

Considering the ageing of the population and the increase in global chronic diseases, the number of individuals in need of palliative care is rising. Nurses who are in charge of the care of palliative care patients have serious responsibilities (23). Therefore, in this study, the challenges faced by palliative care nurses in the palliative care process are discussed within the literature.

Of the nurses participating in the study, 49.1% of the nurses were in the 31-40 age group, 92.5% were female, 75.5% had a bachelor's degree, 67.9% had an average of 1-10 years of work experience, and 82.1% worked with palliative care patients for 0-5 years. These results show that the majority of the nurses participating in the study were middle-aged and female (Table 1). When the literature is examined, it is seen

that there are studies that have similar results to our study findings in terms of age group, gender, educational status, and work experience (24,25).

The challenges faced by the nurses participating in the study while giving palliative care were as follows; excessive workload (11.7%), insufficient number of caregivers/personnel (10.9%), and the attitude of patients' relatives (9.9%) (Table 2). In addition, our study findings are similar to some studies in the literature (20, 26). When these results are taken into consideration, it is seen that palliative care nurses have difficulties due to insufficient number of personnel, excessive workload and attitudes of patients' relatives.

In the study, the total mean score of PCDS, which consists of items describing palliative care difficulties and showing that the challenges experienced by nurses who provide palliative care rise with the increase in the score obtained, was determined as 42.8±7.69, the lowest score 22, and the highest score 61 (Table 3). In one study, the average score of nurses which is obtained from PCDS was 30.58±24.71 (27), whereas, in other studies, it is 42.3±10.3, (28) and 44.90±6.64 (29). When the study findings were assessed, it could be said that the nurses had an above-average difficulty while working in palliative care centers. These results suggest that the difficulties faced by palliative care nurses should be identified and interventions should be taken to alleviate their burden.

Although the number of male nurses in the study was less than female nurses, the communication in multidisciplinary teams sub-dimension scores of male nurses were higher than female nurses (Table 4). According to a study, there is a significant difference between the PCDS and the gender variable, and the findings are consistent with our study findings (30). These results suggest that gender is an important factor in the difficulties experienced in palliative care and that men experience more problems in team communication than women.

Considering the study, single nurses had higher scores on reduction of symptoms sub-dimension (Table 4). These findings suggest that marital status of nurses may have an effect on their symptoms in palliative care. Married nurses have different roles (spouse, mother, father, etc.) compared to single nurses. So, they may have developed the ability to look at the events they encounter from different perspectives. With this acquisition, married nurses may have higher problem-solving skills, and thus, it may be possible that they provide various care services compared to single nurses in controlling the patients' symptoms. The relevant literature findings supporting this result could not be reached.

Again, nurses who see sociocultural factors as palliative care barriers had significantly higher scores in the reduction of symptoms sub-dimension and total score averages (Table 4). The values, beliefs, and attitudes of palliative care patients and their relatives are shaped by the environment in which they live (35). In Chuah's (2017) study, which examined the palliative care experiences of nurses working in oncology services, he found that conflicting expectations from families and language and cultural differences hindered effective palliative care for patients (36). Nurses are in constant interaction with patients and their relatives from different cultural backgrounds in the changing world (37). To provide special nursing care services to palliative care patients, they should be aware of the patient's cultural values (38). It is stated that nurses have difficulties in interacting with patients far from their cultural norms, in communication due to language differences, and not knowing how the applied nursing interventions are received by the patient (7,39). In line with these results, adding an intercultural nursing course to the nursing education curriculum and training palliative care nurses about the cultures of inpatients will be effective.

In literary studies conducted with palliative care nurses, excessive workload, lack of communication, and lack of knowledge and resources on the subject are shown among palliative care barriers (11,31). When the literature is examined, there are studies supporting our research findings (Table 5) which are emphasizing that it is crucial to increase the number of nurses, reduce their workload, and provide necessary training in facilitating palliative care (7,32). The findings suggest that nurses' excessive workload, lack of communication, information and resources hinder palliative care.

This showed that due to the high workload of the nurses, they could not allocate enough time to communicate with specialists and other units, and they had difficulty in reducing the symptoms and caring for the patients.

These findings suggest that physical factors may increase nurses' palliative care difficulties. Therefore, it has a great importance to carry out studies to eliminate physical factors (Table 5). According to the Quality Standards in Health (Hospital) published by the Ministry of Health in Türkiye, it is stated that the physical conditions of palliative care clinics should be arranged to ensure the comfort of patients and their relatives (rooms with daylight and fresh air, but noise) (33). According to Kyc et al. (2020), in which there are studies supporting our findings, list the consequences of inadequate physical conditions in palliative care units as follows; affects the work of nurses negatively, especially when the number of patients in the rooms is high, makes it hard to create an effective communication environment, and the susceptibility to healthcare-related infections and mortality rates increase (34). These findings suggest that physical factors may increase nurses' palliative care difficulties. So, it is crucial to carry out studies to eliminate physical factors.

According to the results, nurses who see the corporate culture inadequacy as a palliative care barrier had significantly higher PCDS total score averages (Table 5). Corporate culture can be summarized as the values, beliefs, assumptions, and attitudes adopted by the organization's members. Also, it can offer solutions to the uncertainties that arise in the institution (40). In case of a corporate culture barrier, communication is impaired, and individuals in the organization may be reluctant to find solutions to problems, exhibit appropriate behaviours, and be motivated (7,41). In the study by Eskigulek and Kav (2020), it is emphasized that the inadequacy of corporate culture prevents institutional problems and dignified care of palliative care patients (31). Considering these findings, the lack of corporate culture in hospitals causes nurses to have difficulties in providing palliative care. For this reason, it is necessary to establish a corporate culture in hospitals and carry out inspections to eliminate palliative care barriers.

In our study, it was found that nurses who considered mobbing as a barrier to palliative care had difficulty in controlling the symptoms of palliative care patients (Table 5). Palliative care units are complex structures where multiple disciplines work cooperatively (42). When the literature is examined, it is seen that it is similar to our findings and emphasizes the following; the mobbing towards the employees in health institutions is high, the job satisfaction of the nurses is negatively affected unless precautions are taken against mobbing, and in-house work motivations and patient care quality have decreased (43,44). According to these findings, it is thought that nurses exposed to mobbing have difficulty in controlling the symptoms of palliative care patients.

Considering that a different specialist should be consulted for the patient in case of limited autonomy of nurses, the fact that the specialist cannot be reached, inter-unit coordination is not supported by adequate policies, and the physicians do not want to accept the poor prognosis of the patients and insist on medical treatment suggest that nurses face difficulties in controlling the symptoms (45). In a study, it is stated that when nurses cannot make a one-to-one decision during care, they experience difficulties when patients and their relatives refuse treatment (20). Aldridge et al. (2016), emphasized that the lack of adequate regulations on palliative care is a barrier (6). In another study, it is concluded that a safer working environment is created after patient visits with physicians (46). According to these results, it is crucial to increase team cooperation and expert support by reviewing the necessary legal regulations for palliative care nurses.

In our study, it was found that nurses who considered economic factors as palliative care negatives had difficulties in symptom reduction and communication coordination (Table 4). There may be situations that require additional costs to control pain and respiratory, and digestive problems which can be observed in palliative care patients. In some studies, it is stated that the expenditures in the palliative care unit consist of drugs and other material expenses, especially antibiotics (47,48). The medical services of palliative care patients who were

discharged from hospitals in Türkiye are met through home health services units. Yet, there are economic barriers to providing equipment such as medicines and medical devices that may be required in home environments (49). However, palliative care is not just care given in a hospital; it is care that continues throughout the patient's life. For this reason, hospital and home care services must work coordinately for palliative care (12). Again, to prevent economic factors from creating difficulties in palliative care, it is necessary to eliminate them and make an improvement in this regard.

Limitations

The research is limited to the answers given to the questionnaire forms by the palliative care nurses and nurses working in the hospitals where the study was conducted.

Implications For Nursing Practice

Nursing care services play a big role in controlling the symptoms of patients given palliative care, increasing their quality of life, and ensuring a good death. For this reason, it is believed that reviewing the necessary legal regulations, regulating the policies, eliminating the personnel and material deficiencies, and continuing the training until all problems are solved are essential to eliminate the factors that cause difficulties in the palliative care units. It is anticipated that the research results will contribute to the literature on the challenges faced by nurses in palliative care and to the development of initiatives to reduce the difficulties.

Conclusion

The difficulties faced by nurses while giving palliative care are as follows; excessive workload, insufficient staff/caregivers, attitudes of patient relatives, patient positioning, psychological problems of patients, physical, economic and socio-cultural barriers, lack of education, mobbing and material inadequacy, the inadequacy of corporate culture, inability to make one-to-one decisions, and intra-team conflicts.

It was concluded that the total mean scores of the palliative care difficulties scale of the nurses working in palliative care services were above average. Since nurses working in palliative care see excessive workload as a palliative care obstacle, it has been determined that they struggle with expert support, reducing symptoms and coordination of communication. Also, the palliative care nurses see mobbing and the inadequacy of institutional culture as palliative care barriers and have difficulties in care.

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Conflict of Interest

The authors declare that there is no conflict of interest.

Contact: Sibel Özdemir Özmen
E-Mail: sibelozdemirozmen@gmail.com

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