



EXPLORING THE CRITICAL ROLE OF NURSES IN THE PALLIATIVE CARE.

Nasser Dakhilallah Alrashidi

Abdullah Maayouf Alanezi

Nawal Ali Alshaikhahmad

Fatimah Abdullah Asiri

Mohammad Ahmed Mohammad Alzhrani

Mutabmarshoobalkareeni

Mohammed faleh Al Muteri

Turki Mohammed Alsahli

Huda Abdullah Alqurashi

Lueife Ali Eid Al Rashedi

Norah Mawaad Rubaian Alrashidi

Raid Azem Al Dawsary

Wafa Bashar Alruwaili

Ali Yahya Alqahtani

Zahra Ali Hazazi

Abstract:

Palliative nursing care is a multifaceted strategy to address the medical, psychological, social, and spiritual needs of patients with terminal illnesses. This essay looks at several facets of providing palliative care, from the necessity of creating palliative care services in primary care settings to the critical function community nurses have in providing individualized home care. It explores the intricacies of managing symptoms, tackling typical physiological and psychological indications such as discomfort, exhaustion, nausea, worry, and sleeplessness. In addition, the talk delves into ethical issues surrounding palliative care, emphasizing how crucial it is to preserve



All the articles published by Chelonian

Biology are licensed under a [Creative Commons Attribution-](https://creativecommons.org/licenses/by-nc/4.0/)

[NonCommercial 4.0 International License](https://creativecommons.org/licenses/by-nc/4.0/) based on a work at <https://www.acgpublishing.com/>

Conservation

and

values like beneficence, autonomy, and advocacy when making decisions. The topic of family engagement in caring is also covered, with a focus on the importance of clear communication, education, and support in order to protect the health of patients as well as their loved ones. Moreover, the necessity of ongoing education and having access to trustworthy resources is highlighted by the integration of evidence-based methods into nursing care. Through the adoption of a comprehensive strategy, the prudent handling of moral quandaries, and the promotion of cooperation among patients, families, and multidisciplinary teams, nurses can maintain the best possible standards of care for those facing the end of their life. This essay seeks to shed light on the intricacies of palliative nursing care and emphasize the value of person-centered, compassionate assistance in improving the quality of life for those with terminal diseases.

Key words: Nursing, Palliative care, medical care, pain management, evidence-based.

Introduction:

Globally, the incidence of non-infectious and chronic diseases has increased, which has increased the need for palliative care among the elderly and patients with life-threatening conditions. An estimated 40 million people are thought to need palliative care each year, and 78% of them live in low- and middle-income countries [1,2]. Recognizing this growing demand, palliative care should be made available in a variety of settings, such as homes, hospitals, outpatient clinics, and care centers, according to the World Health Organization and the Worldwide Palliative Care Alliance [1, 3, 5, 6]. In addition to a host of bodily discomforts, patients with life-threatening illnesses also deal with psychological and spiritual issues [7,8,9]. The use of healthcare services during the end-of-life stage increases as patients' circumstances worsen [5,6]. Studies show that most patients indicate a desire to die comfortably in their homes during their last days; however, a considerable number pass away in hospital settings, frequently in less than ideal circumstances [4,10]. This emphasizes how important it is to launch comprehensive community-based care programs. As a result, palliative care provision in patients' homes is given top priority in most national health plans [4,10].

The development of palliative care services within primary care settings is crucial for meeting the expectations of individuals nearing the end of life. Various factors underscore the necessity of palliative care in community settings, including the psychological strain associated with managing symptoms, the discomfort of dying in an unfamiliar environment among unfamiliar individuals, the burdensome reliance on life-support measures, the inadequacy of available medical and disease-focused care models, prolonged hospital stays, the financial strain of caring for terminally ill patients, and the scarcity of palliative care specialists in hospitals [11,12]. Palliative care delivered in the home setting aims to optimize the patient's quality of life by mitigating the adverse effects of the illness, addressing emerging issues with suitable medical and nursing interventions, and minimizing disruptions to the patient's living environment to facilitate a comfortable death when the time arrives [13]. Patients express a preference for

receiving care at home rather than in hospitals [3,10] due to the familiarity of the home environment, the preservation of their normal routine, and the ability for family members to take charge. Numerous documented benefits are associated with palliative care delivered at home [3,8,9,13,14], including alleviating the burden of symptoms on both the patient and their family, enhancing compliance with care and treatment, promoting recovery, increasing satisfaction among patients and families, reducing hospital, intensive care unit, and emergency room visits, minimizing hospitalizations, maintaining family cohesion, preserving the patient's autonomy, facilitating participation in family and social activities, reducing the risk of infections, offering personalized care, alleviating stress for patients and their families, reducing short-term costs, ensuring continuous healthcare from diagnosis to recovery, and enhancing overall quality of life. The objectives of palliative care at home may vary based on the specific needs of the patient and their family. The nature and frequency of palliative care interventions may evolve as the patient's needs change, the disease progresses, and the complexity of required care increases. Typically, the provision of care is tailored to meet the preferences and expectations of the patient [10].

Community Nurses:

In palliative care, a committed team collaborates to fulfill the various needs of patients, including those that are physical, psychological, social, spiritual, and cultural. The team also offers support to caregivers and relatives. This multidisciplinary team, which provides continuous and coordinated supportive care in the community, usually consists of doctors, nurses, allied health professionals, volunteers, and caregivers. The community nurse is one of these specialists who plays a crucial part in the palliative care team [15]. According to the literature, "community nurse" refers to a variety of titles and tasks that nurses carry out when providing palliative care, such as advanced practice registered nurse, home care nurse, public health nurse, and district nurse [16,17,18,19,20, 21]. The term "community nurse" will be used consistently throughout this work to refer to all members of the nursing team involved in community-based palliative care, regardless of the diversity of titles and duties. Community nurses carry out crucial tasks and duties in the context of home care. Their job is to carefully design, coordinate, and carry out efficient treatment plans that are customized to meet the needs of each patient. Community nurses are committed to improving the quality of life for patients of all ages and supporting their families and significant others. Their work is underpinned by the fundamental values of the nursing profession. Community nurses' duties include collecting patient and family data in a methodical manner in order to identify relevant issues, rank them appropriately, plan and carry out the necessary nursing interventions, and evaluate the results of these interventions [22,23,24].

Assessment of Palliative Care:

Data collection, the first step in the nursing process, includes an assessment meant to determine the care needs of the palliative care patient as well as their family [25]. A thorough

awareness of the patient's needs is essential for the successful administration of palliative care at home; hence the community nurse's data collection and assessment are crucial. In order to determine the patient's and their family's needs for at-home care, a number of elements should be evaluated during the assessment. The patient's degree of independence in carrying out daily tasks, disease-specific symptoms, nutritional status, cognitive functioning, communication skills, personal expectations, adjustments to familial and work relationships, understanding of the illness, available treatment options, prognosis, and coping mechanisms are a few of these.

In addition, the community nurse needs to evaluate the patient's caregivers to determine how well they comprehend the illness, how much information they require, and how they see its consequences and available therapies. Along with evaluating the home environment, family resources, roles and connections, social support networks, expectations, and the effect of the illness on the family, this assessment should also identify critical priorities. Assessing the home environment is also essential to make sure it is appropriate for the patient's treatment. In order to provide comfort and safety for both present and future care needs, the community nurse must evaluate the physical surroundings. This involves evaluating the safety of the bathroom and bedroom, making sure the house is set up for nursing interventions, and having medical equipment stored safely. These evaluations also take the patient's social and financial resources for support into account [26, 27].

Nursing Diagnosis:

Following data collection, the community nurse proceeds to evaluate the gathered information and formulate nursing diagnoses, with common diagnoses in palliative care patients at home encompassing pain, respiratory distress, fatigue, activity intolerance, impaired body image, and social isolation [28]. Planning involves delineating the required interventions for identified issues, specifying what, how, and when actions are needed, and devising strategies for patient and family involvement. Patient and family engagement in home care correlates positively with satisfaction levels. Nurses must exercise particular care in catering to the needs of specific home care patients, who may encounter challenges due to their unique circumstances.

Vulnerable patients in home care encompass those with complex or poorly managed conditions, multiple symptoms, or comorbidities, undergoing intricate treatments, living alone, elderly or weak individuals, lacking caregiver support, embroiled in family disputes, bedridden, or lacking medical insurance. Nursing interventions must be evidence-based, scientifically grounded, and compliant with regulations, tailored to the patient's diagnosis, symptom severity, psychosocial status, and disease progression. Effective symptom management enhances quality of life and facilitates a peaceful end-of-life experience. Evaluation involves ongoing assessment during home visits to identify and address issues amenable to nursing interventions. Referral to appropriate care facilities is warranted when needs surpass the scope of home care. Documentation of all home care activities is imperative for continuity of care, evaluation,

and communication among team members. Community nurses' roles and functions in home care vary depending on patient-specific factors, summarized in Table 2 [29, 30].

In palliative care, community nurses play a crucial role in symptom management, employing the nursing process to assess, plan interventions, and provide care [31,32,33]. For cancer patients requiring palliative care at home, common physical and psychosocial symptoms necessitate tailored nursing interventions. Pain, characterized by unpleasant sensations from any body part, arises from diverse causes, including tissue damage and tumor-related changes. Acute pain triggers physiological responses and behavioral manifestations, while chronic pain poses challenges to daily functioning and disrupts sleep patterns [26, 28, 34]. Nursing interventions for pain management encompass comprehensive assessment, pharmacological treatment, patient and family education, and the provision of non-pharmacological interventions like massage and music therapy. Fatigue, a subjective symptom ranging from mild burnout to debilitating exhaustion, stems from various physiological, psychological, and treatment-related factors. It impairs daily functioning, concentration, and social interactions [28-34]. Nursing interventions for fatigue management involve assessing its impact, addressing underlying causes, providing supportive care, and offering strategies to enhance energy conservation and coping mechanisms. In summary, community nurses play a pivotal role in addressing the complex symptoms experienced by palliative care patients at home, employing holistic approaches to enhance their quality of life and promote comfort and well-being.

Nursing Interventions:

Fatigue: The community nurse conducts a comprehensive assessment of the patient's fatigue, including symptoms, severity, and underlying causes, and evaluates its impact on the patient's daily life. Laboratory findings are examined to identify potential contributing factors, and the patient and family are educated about fatigue management strategies. The environment is optimized to reduce the patient's energy consumption, and support is provided for daily activities. The patient is encouraged to rest and taught energy-saving techniques. Alternative treatments such as therapeutic touch and yoga may be recommended, and assistance is offered for household tasks. Emphasizing the importance of sleep hygiene, the nurse encourages the patient to engage in social activities of interest. **Loss of Appetite:** Anorexia, characterized by decreased energy intake and reduced desire to eat, is addressed through a thorough nutritional assessment. Factors contributing to inadequate nutrient intake are identified, and a tailored nutritional program is developed based on the patient's disease and prognosis. Meals are planned to be small and frequent, incorporating high-protein and high-calorie foods while avoiding fatty and spicy foods. Antiemetic drugs may be administered to prevent nausea and vomiting, and the patient's weight is closely monitored. Nutrition education is provided to the patient and their family to support dietary management.

Nausea and Vomiting: The nurse evaluates the type, severity, and potential causes of nausea and vomiting and implements strategies to alleviate symptoms. Dietary adjustments,

including eating small amounts slowly and avoiding certain foods, are recommended to minimize gastrointestinal distress. Environmental factors such as odors and sounds are considered, and proper oral hygiene is maintained. The patient is educated in nausea-reducing techniques and provided with antiemetic medication as needed. Relaxation and distraction exercises may be encouraged before meals to reduce meal-related stress and increase appetite. Constipation: The nurse assesses the patient's bowel function and implements interventions to promote regular bowel movements. Dietary modifications, including increased fluid and fiber intake, are recommended, and natural foods such as prunes, and prune juice may be provided. Laxatives are prescribed as ordered, and rectal suppositories and enemas are avoided in patients with specific medical conditions. The patient is encouraged to maintain mobility and engage in physical activity to support bowel function.

Dyspnea: Defined as a challenging and uncomfortable sensation of breathing difficulty, dyspnea can arise from various causes including anemia, anxiety, ascites, cerebral tumors, and heart or kidney failure. Patients may exhibit symptoms such as wheezing, fatigue, and feelings of breathlessness. Nursing interventions involve evaluating the patient's breathing pattern and its impact on daily life, addressing underlying causes, and providing supportive care such as positioning the patient properly, encouraging breathing exercises, ensuring hydration, and administering appropriate medications. Oxygen therapy may be provided if necessary. Delirium: Characterized by disturbances in cognitive functions, consciousness, attention, and orientation, delirium can result from factors like infections, metabolic disorders, trauma, and circulatory shock. Symptoms may include hyperactive, hypoactive, or mixed presentations, with varying levels of agitation, psychomotor slowing, and disorientation. Nursing interventions focus on symptom management, regulating fluid and electrolyte balance, evaluating nutritional status, creating a calm environment, and providing familiar objects for grounding.

Anxiety: Intense internal distress and restlessness characterize anxiety, which can stem from factors like continuous medical procedures, uncertainties about the disease and treatment, and changes in social roles. Symptoms may include restlessness, chest tightness, and insomnia. Nursing interventions involve assessing anxiety levels and causes, facilitating open communication between patients and their families, providing information and support, and fostering a trusting patient-nurse relationship. Patients are encouraged to participate in their care process and engage in relaxation techniques. Fear: Fear is an emotional response to real or perceived danger, often arising from the disease itself, hospitalization, or medical procedures. Symptoms may include anxiety, sleep disturbances, and crying. Nursing interventions include identifying and addressing patient fears, encouraging expression of feelings, maintaining routine activities, creating a supportive environment, and teaching relaxation techniques to manage fear and anxiety effectively.

The term "insomnia" describes problems falling asleep, staying asleep, or having poor quality sleep even under the right circumstances. There could be several contributing factors, such as those pertaining to the patient, the illness, the therapy, and the surroundings. Insomnia

can be caused by a number of factors, including the kind and severity of the illness, hormone therapy, chemotherapy, pain, and psychological problems like sadness and worry. The symptoms could include restlessness throughout the day, nightmares, difficulty falling asleep, and irritability. A comprehensive strategy is used in nursing interventions for insomnia, with the goal of assessing the patient's sleep habits, determining the underlying causes, and putting into practice practical techniques to encourage improved sleep hygiene. In addition to addressing any other symptoms that can aggravate insomnia, nurses evaluate the patient's typical sleeping patterns and explain how the treatment would affect sleep. Non-pharmacological interventions include things like massages, warm milk, calming music, progressive muscle relaxation techniques, and sticking to a regular nighttime schedule. Furthermore, improving the quality of sleep can be achieved by making changes to the surroundings, such as dimming lights and noise, minimizing disruptions from medical operations while you sleep, and encouraging relaxing methods like aromatherapy and yoga. If non-pharmacological therapies are shown to be insufficient, pharmaceutical treatments may be explored with medical guidance.

Nursing Support to Family:

Family members now play a more important and varied role in the field of home palliative care. Since this type of care has developed into a more complex modality that includes things like the administration of opioids and symptom management, family members who take on the role of main caregivers are now responsible for more. These responsibilities go beyond just giving medical attention; they also consider the patient's unique requirements and the dynamics of the caregiver-patient relationship. Furthermore, family caregivers frequently balance other familial responsibilities in addition to their caring tasks, which adds to the complexity of their work. An essential component of home palliative care's efficacy is the nurse's continuous family communication. The nurse's responsibility is to evaluate the caregivers' duties and their relationship with the patient, giving pertinent information that is crucial to the patient's care. Given that family caregivers could experience physical and psychological difficulties of their own, nurses need to establish a safe space where caregivers feel comfortable sharing their worries. After doing a thorough assessment of the caregivers' requirements, the nurse develops specialized solutions to lessen their physical and psychological loads. Furthermore, nurses are essential in recognizing stressors in the family dynamic and providing caregivers with coping skills.

Additionally, nurses take on the duty of providing family caregivers with the instruction and guidance they require, equipping them with the know-how and abilities needed to provide patients with quality care. In the home palliative care setting, nurses play a critical role in providing patients and their families with comprehensive support by attending to both the practical and emotional aspects of caregiving.

Evidence Based Practices:

The concept that healthcare evaluation should rely on scientific evidence rather than clinical intuition emerged in the 1970s. Since then, evidence-based healthcare has gained prominence, permeating various fields, including nursing. Evidence-based nursing transcends the mere application of research findings, requiring nurses to evaluate risks, benefits, costs, inconveniences, and patient preferences alongside proposed care. In the context of palliative care, these considerations are particularly critical given the intricate interplay of patient vulnerability, diagnosis, prognosis, care goals, and the swiftly evolving evidence base. To exercise informed clinical judgment, nurses must possess the necessary skills to effectively integrate evidence with their clinical expertise and patient preferences. Despite holding positive attitudes toward evidence-based practice, recent studies indicate that many nurses engage minimally in evidence-based care provision. Staying abreast of new evidence poses a challenge, prompting the development of publicly accessible websites such as CareSearch (www.caresearch.com.au), Cochrane Library, Joanna Briggs Institute, and eviQ, all offering specialized evidence-based resources relevant to palliative care.

After locating evidence, the next hurdle lies in critically appraising it rigorously. Every nurse must, at a minimum, possess the ability to evaluate a study's methodological strengths and weaknesses before assessing its results, relevance, and applicability to their practice. Critical appraisal tools available on platforms like the Critical Appraisal Skills Program (CASP) and Joanna Briggs Institute website furnish nurses with a structured framework to systematically scrutinize research evidence for its credibility and pertinence. However, transitioning from "best evidence" to "best practice" demands coordinated efforts at the system level. Nurses wield significant influence in integrating the best evidence into day-to-day decision-making and care delivery. As they shape palliative care practice across various roles, ranging from bedside care in institutional settings to advanced nurse practitioner roles, it is imperative for every nurse to contemplate how they can promote and integrate evidence-based care into all healthcare decisions.

Ethical Considerations:

The provision of palliative nursing care to vulnerable patients often brings forth ethical challenges that require careful consideration. Nurses rely on principles such as beneficence, non-maleficence, autonomy, and justice to navigate these complexities and uphold ethical standards. Common ethical dilemmas encountered include assessing competency to consent, advocating for patients, and making decisions regarding treatment withholding or withdrawal. Assessing a patient's competency to consent is crucial for respecting their autonomy while ensuring their protection if they are unable to make decisions. In cases where competency is lacking, nurses must seek substitute decision-makers and provide competent patients with comprehensive information to facilitate informed choices about their care. Vulnerable palliative patients may be susceptible to external influence, highlighting the nurse's role as an advocate to ensure the

patient's voice is heard and their choices respected. Nurses, with their extensive patient interaction, are uniquely positioned to advocate for patients' preferences, symptom management, and cultural and spiritual needs. This advocacy extends beyond speaking on behalf of the patient to empowering them to express their preferences independently.

Nurses also play a pivotal role in decision-making processes concerning treatment initiation, continuation, or cessation, considering the balance between benefits and burdens. While physicians often lead these decisions, nurses' input is indispensable. It's crucial for nurses to distinguish between withholding or withdrawing treatment, which aims to minimize burden and improve quality of life, and euthanasia, which aims to end life. Requests for euthanasia or assisted suicide may arise from families, requiring careful exploration of underlying concerns and consideration of alternative interventions.

Conclusion:

In conclusion, the discussion on palliative nursing care underscores the multifaceted nature of providing end-of-life support to patients and their families. From the importance of developing palliative care services in primary care to the critical role of community nurses in delivering personalized care at home, it is evident that a holistic approach is essential in addressing the diverse needs of individuals facing life-limiting illnesses. The integration of evidence-based practices into nursing care is paramount, necessitating continuous education and access to reliable resources to ensure the delivery of optimal care. Moreover, ethical considerations loom large in palliative care, as nurses navigate complex decisions regarding consent, advocacy, and treatment options. Upholding principles of beneficence, non-maleficence, autonomy, and justice is foundational to maintaining ethical integrity while honoring patients' preferences and ensuring their well-being. The involvement of family members in palliative care adds another layer of complexity, with nurses playing a pivotal role in supporting both patients and their loved ones through the challenges of caregiving. Effective communication, education, and collaboration are vital in fostering understanding and shared decision-making among all stakeholders involved in the care process. In addressing symptom management, nurses must draw upon their clinical expertise and evidence-based knowledge to alleviate pain, dyspnea, insomnia, and other distressing symptoms effectively. The ability to critically appraise research evidence and translate it into practice underscores the importance of ongoing professional development and access to relevant resources. Ultimately, the essence of palliative nursing care lies in providing compassionate, person-centered support that respects the dignity and autonomy of each individual. By embracing a holistic approach, integrating evidence-based practices, navigating ethical dilemmas judiciously, and fostering collaboration with patients, families, and interdisciplinary teams, nurses can uphold the highest standards of care for those navigating the end-of-life journey. Through their dedication and expertise, nurses continue to shape and enhance the quality of palliative care, ensuring that patients receive the comfort, dignity, and support they deserve during life's final stages.

References:

1. Worldwide palliative care alliance: global atlas of palliative care at the end of life. 2014. http://www.who.int/nmh/Global_Atlas_of_Palliative_Care.pdf. Accessed 29 Feb 2020.
2. Etkind SN, Bone AE, Gomes B, Lovell N, Evans CJ, Higginson IJ, et al. How many people will need palliative care in 2040? Past trends, future projections and implications for services. *BMC Med.* 2017;15(1):102.
3. Chiang JK, Kao YH. Impact of home hospice care on patients with advanced lung cancer: a longitudinal population-based study in Taiwan. *J Palliat Med.* 2016;19(4):380–6.
4. Stjernswärd J. Palliative care: the public health strategy. *J Public Health Policy.* 2007;28(1):42–55.
5. Murray SA, Firth A, Schneider N, Van den Eynden B, Gomez-Batiste X, Brogaard T, Villanueva T, Abela J, Eychmuller S, Mitchell G, Downing J. Promoting palliative care in the community: production of the primary palliative care toolkit by the European Association of Palliative Care Taskforce in primary palliative care. *Palliat Med.* 2015;29(2):101–11.
6. Mitchell G. Rapidly increasing end-of-life care needs: a timely warning. *BMC Med.* 2017;15(1):126.
7. Burge F, Lawson B, Johnston G, Asada Y, McIntyre PF, Flowerdew G. Preferred and actual location of death: what factors enable a preferred home death? *J Palliat Med.* 2015;18(12):1054–9.
8. Peters L, Sellick K. Quality of life of cancer patients receiving inpatient and home-based palliative care. *J Adv Nurs.* 2006;53(5):524–33.
9. Lai XB, Chen LQ, Chen SH, Xia HO. An examination of home-based end-of-life care for cancer patients: a qualitative study. *BMC Palliat Care.* 2019;18(1):1–1.
10. Thomas K. Out-of-hours palliative care in the community. Continuing care for the dying at home. London: Macmillan Cancer Relief; 2001.
11. De Lima L, Pastrana T. Opportunities for palliative care in public health. *Annu Rev Public Health.* 2016;37:357–74.
12. European Association of Palliative Care (EAPC) task force in primary palliative care.
13. Wiencek C, Coyne P. Palliative delivery models. *Seminars in Oncology Nursing.* 2014;30(4):227–33.
14. Appelin G, Brobäck G, Berterö C. A comprehensive picture of palliative care at home from the people involved. *Eur J Oncol Nurs.* 2005;9(4):315–24.

15. Dunne K, Sullivan K, Kernohan G. Palliative care for patients with cancer: district nurses' experiences. *J Adv Nurs*. 2005;50(4):372–80.
16. King N, Melvin J, Ashby J, Firth J. Community palliative care: role perception. *Br J Community Nurs*. 2010;15(2):91–8.
17. Austin L, Luker K, Caress A, Hallett C. Palliative care: community nurses' perceptions of quality. *BMJ Quality & Safety*. 2000;9(3):151–8.
18. Luker KA, Wilson K, Pateman B, Beaver K. The role of district nursing: perspectives of cancer patients and their carers before and after hospital discharge. *Eur J Cancer Care*. 2003;12(4):308–16.
19. Fitzgerald GP, Naugle MA, Wolf JP. The palliative advanced practice registered nurse in the home setting. *Adv Pract Palliat Nurs*. 2016;25:180.
20. Sekse RJ, Hunskår I, Ellingsen S. The nurse's role in palliative care: a qualitative meta-synthesis. *J Clin Nurs*. 2018;27(1–2):e21–38.
21. Maybin J, Charles A, Honeyman M. Understanding quality in district nursing services. London: Kings Fund; 2016.
22. McKenzie H, Boughton M, Hayes L, Forsyth S, Davies M, Underwood E, McVey P. A sense of security for cancer patients at home: the role of community nurses. *Health Soc*
23. Walshe C, Luker KA. District nurses' role in palliative care provision: a realist review. *Int J Nurs Stud*. 2010;47(9):1167–83.
24. Canadian Nurses Association. Joint position statement: the palliative approach to care and the role of the nurse. Available from: www.cna-aiic.ca/~media/cna/page-content/pdf-en/the-palliativeapproach-to-care-and-the-role-of-the-nurse_e.pdf. 2015.
25. Kuebler KK, Lynn J, Von Rohen J. Perspectives in palliative care. *Seminars in Oncology Nursing*. 2005;21(1):2–10.
26. Ferrell BR, Coyle N, Paice J, editors. *Oxford textbook of palliative nursing*. New York: Oxford University Press; 2015.
27. Dahlin C, Coyne P, Ferrell BR, editors. *Advanced practice palliative nursing*. New York: Oxford University Press; 2016.
28. Bookbinder M, McHugh ME. Symptom management in palliative care and end of life care. *Nurs Clin*. 2010;45(3):271–327.
29. Palliative Caring at Home. Information for those caring for a person with advanced and terminal illness. Western Australia Edition – January 2012 www.palliativecarewa.asn.au. Accessed 6 Mar 2017.

30. Carter L. Delivering palliative care in the community: community nurses' experiences and perceptions of their role. Unpublished masters thesis. University of Nottingham; 2008.
31. End of Life Nursing Education Consortium (ELNEC) APRN curriculum. www.aacn.nche.edu/elnec. Erişim Tarihi 9 February 2018.
32. Milone-Nuzzo P, Ercolano E, McCorkle R. Home care and hospice care. In: Oxford textbook of palliative nursing. New York: Oxford University Press; 2015.
33. NCCN clinical practice guidelines in oncology 2008. http://www.nccn.org/professionals/physician_gls/PDF/occult.pdf.
34. North of England Cancer Network (NECN) 2012. Palliative and end of life care guidelines for cancer and non-cancer patients. <https://southtees.nhs.uk/content/uploads/NECN-palliative-care-guidelines.pdf>.