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Original Research Article

Clinical Nurses' Knowledge and Attitude on Palliative Care: A Cross-Sectional Study

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ABSTRACT:

Introduction: Palliative care is a multidisciplinary approach for enhancing the quality of life of terminally ill patients. For nurses, being the core members of the palliative care team, adequate knowledge and a positive attitude are crucial. This study aimed to assess clinical nurses' knowledge and attitude on palliative care. **Method:** A cross-sectional descriptive study was conducted among 122 nurses. A simple random sampling technique was applied to select the sample. Internationally validated questionnaires-"The Palliative Care Quiz for Nursing" and "Frommelt Attitudes Toward Care of the Dying Scale" were used to assess knowledge and attitude. Data were analyzed using descriptive statistics and inferential statistics. **Results:** The mean age of participants was 25±5.42 years and a majority (70.5%) were staff nurses. None of the participants had ever received training or in-service education related to palliative care. Only 29.5% had a fair level of knowledge and, 28.7% had a good level of attitude towards palliative care. Pearson correlation test revealed a negligible correlation between the level of knowledge and attitude (r= 0.135, p=0.887). Ethnicity (p=0.02) and religion (p=0.02) were statistically significant with the level of knowledge and care for dying relatives (p=0.03) was statistically significant with the level of attitude. **Conclusion:** The study revealed that nurses' have poor knowledge of palliative care but had a fair attitude. As nurses are core members, regular training and in-service education can enhance their knowledge level. Positive reinforcement, appreciation, and reward for desirable behavior can help them develop a good attitude towards palliative care.

Keywords: Attitude; Knowledge; Nurse; Palliative care

INTRODUCTION:

Dying and death is an inevitable universal phenomenon that brings a very bitter experience for both patients and their families, and palliative care could bring a ray of hope to soothe them at their end-of-life care.[1,2] Palliative care, as described by WHO, *is 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 sufferings by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual*.[2] It can be started at any point after diagnosis of any chronic and/or terminal diseases along with other therapies to maintain quality of life, prolong life, and distress-related complications at centers like the hospital, daycare centers, or even at the patient's own home.[3,4]

The global need for palliative care is on an increasing trend due to the rising aged population, chronic non-communicable and terminal staged diseases.[3] End-of-life care or care for the dying is the care provided in the final days or weeks before the death of patients so hospice care is a final phase of palliative care.[2,5] For the successful delivery of palliative health care, sound knowledge and positive attitude of health care professionals especially of nurses, who are the main interventionist, is very fundamental.[6,7,8] Studies conducted in different countries have shown relatively poor knowledge

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but a positive attitude towards palliative care among nurses.[6,8] Though assessment of knowledge and attitude of nurses towards palliative care has received considerable global attention from the researchers, very limited studies are available in the Nepalese context. Therefore, this study was aimed to find out the knowledge and attitude of clinical nurses on palliative care.

METHODS:

A cross-sectional descriptive study design was adopted to assess the nurses' knowledge and attitude towards palliative care. Ethical approval was taken from the Institutional Research Committee of Lumbini Medical College and Teaching Hospital (IRC-LMC 05-G/020).

The sample size was estimated using Solvin's formula, n= N/(1+Ne2) were, total population(N)=175 and allowable error (e)=0.05 and calculated sample size(n) was 122. The desired sample was taken from computer-generated simple random numbers. Nurses who were absent or in long leave during data collection were replaced by other randomly generated numbers. Those registered nurses (Auxillary Nurse Midwives, Proficiency Certificate Level and Bachelor graduates) working in critical areas- intensive care unit, pediatric intensive care unit, neonatal intensive care unit, emergency department and post-operative ward; non-critical areas- general medical ward, surgical ward, gynecological ward, pediatric ward, and orthopedic ward of Lumbini Medical College and Teaching Hospital (LMCTH) and who gave voluntary consent for the participation in the study were included. Whereas, nurses who are working in outpatient departments, and operation theatre were excluded. The data was collected over March 2021. Questionnaires were filled in the presence of the researcher and around 20 minutes were taken by each participant. Confidentiality and anonymity were strictly maintained.

The self-administered questionnaire used in this study consisted of three parts: Part I: Socio-demographic variables. Part II: knowledge related questions were assessed by "Palliative Care Quiz for Nursing (PCQN)" and Part III: "Frommelt Attitude toward the Care of the Dying Scale (FATCOD)" to assess the attitude. PCQN and FATCOD are validated questionnaires in which the former had high content validity, and reasonable reliability (the internal consistency = 0.78 and test-retest = The correlation coefficient=0.56) and the latter had Cronbach's alpha coefficient 0.83.[9,10] PCQN consisted of 20 items as (a) philosophy and principles of palliative care (1-4), (b) management of pain and other symptoms (5-17), and (c) psychosocial aspects of care (18-20). The response options were true, false, and I don't know. The right answer was graded as '1' and for incorrect and don't know were graded as '0'. The total score was 20 which was converted into a percentage score and classified into three categories based on the study conducted in Egypt as poor knowledge (<50%), fair knowledge (50 - <75%), and good knowledge (≥75%).[11]

FATCOD is a five-point Likert scale ranged from 1= strongly disagree to 5=strongly agree which has 30 items divided into three domains: (a)cognitive domain (12 items): 1,2,6,10,11,17,19,21,23,25,27,30 (b) affective domain (9 items):3,5,7,8,9,13,14,15,26 and (c) patient's family (9 items): 4,12,16,18,20,22,24,28,29.[10]There were 15 items (3, 5, 6, 7, 8, 9, 11, 13, 14, 15, 17, 19, 26, 28, and 29) that needed reverse scoring. The scores ranged from 30 to 150. The total attitude scores were further classified into poor (<50%), fair (50 - <75%), and good (≥75%).[11]

The questionnaire was translated in Nepali version and pretested among 12 nurses working in the operation theatre and Cronbach's alpha coefficient value was 0.71 for PCQN and 0.81 for FATCOD.

The collected data were checked for completeness, coded and entered in Microsoft Excel 2007, and transformed in Statistical Package for the Social Sciences (SPSS) version 16. Descriptive statistics- frequency, percentage, mean, standard deviation, and range; and inferential statistics (chi-square test) were used for the analysis of data. The p-value was set at <0.05 for statistical significance.

RESULTS:

A majority (65.5%) of participants were from the age group <25 years with a mean ± SD of 25±5.42 years (range:18 to 45 years). More than half (53.3%) of the participants were Janajati followed by 41.8% Brahmin/ Chhetri and 4.9% Dalit. A majority (94.3%) of the participants were Hindus. A majority (70.5%) were staff nurses, 19.7% were Auxiliary Nurse Midwives (ANM) and 9.8% were bachelor graduates. The mean job experience of participants was 3.43±3 years ranging from 0.3 to 15 years.

Most (88.5%) of the participants had an experience of caring for dying patients whereas, 38.5% had an experience of caring for their dying relatives. One-third (33.6%) of them were working in critical areas. None of the participants had received any pieces of training or in-service education related to palliative care.

Two-thirds (64.8%) of participants stated palliative care was appropriate only in situations where there is evidence of a downhill trajectory or deterioration. Less than half (40.2%) of participants agreed that the provision of palliative care requires emotional detachment. A majority (86.1%) answered that the extent of the disease determines the method of pain management. Likewise, 87.7% assumed that drug addiction becomes the major problem when morphine is used for prolonged

Table 1. Knowledge on palliative care of participants measured by PCQN (n=122).

S. N.	Characteristics	True N (%)	False N (%)	Don't know N (%)
1	Palliative care is appropriate only in situations where there is evidence of a downhill trajectory or deterioration.	79(64.8)	37(30.3)*	6(4.9)
2	The provision of palliative care requires emotional detachment	68(55.7)	49(40.2)*	5(4.1)
3	The philosophy of palliative care is compatible with that of aggressive treatment.	28(23)*	64(52.5)	30(24.6)
4	The accumulation of losses renders burnout inevitable for those who seek work in palliative care.	43(35.2)	56(45.9)*	23(18.9)
5	Morphine is the standard used to compare the analgesic effect of other opioids.	102(83.6)*	8(6.6)	12(9.8)
6	The extent of the disease determines the method of pain treatment.	105(86.1)	14(11.5)*	3(2.5)
7	Adjuvant therapies are important in managing pain.	110(90.2)*	7(5.7)	5(4.1)
8	During the last days of life, the drowsiness associated with electrolyte imbalance may decrease the need for sedation.	70(57.4)*	30(24.6)	22(18.0)
9	Drug addiction is a major problem when morphine is used on a long-term basis for the management of pain.	107(87.7)	10(8.2)*	5(4.1)
10	Individuals who are taking opioids should also follow a bowel regime.	80(65.5)*	14(11.5)	28(23.0)
11	During the terminal stages of an illness, drugs that can cause respiratory depression are appropriate for the treatment of severe dyspnea.	66(54.1)*	35(28.7)	21(70.2)
12	The use of placebos is appropriate in the treatment of some types of pain.	68(55.7)	37(30.3)*	17(13.9)
13	In high doses, codeine causes more nausea and vomiting than morphine.	79(60.8)*	21(17.2)	22(18.0)
14	Suffering and physical pain are synonymous.	41(33.6)	75(61.5)*	6(4.9)
15	Demerol is not an effective analgesic in the control of chronic pain.	48(39.3)*	56(45.9)	18(14.8)
16	Manifestations of chronic pain are different from those of acute pain.	90(73.8)*	25(20.5)	7(5.7)
17	The pain threshold is lowered by anxiety or fatigue.	92(75.4)*	19(15.6)	11(9.0)
18	It is crucial for family members to remain at the bedside until death occurs.	93(76.2)	21(17.2)*	8(6.6)
19	The loss of a distant or contentious relationship is easier to resolve than the loss of one that is close or intimate.	106(86.9)	8(6.6)*	8(6.6)
20	Men generally reconcile their grief more quickly than women.	109(89.3)	10(8.2)*	3(2.5)

* Right answers

periods for pain management. A majority (90.2%) of participants stated that adjuvant therapies are important in managing pain. Three quarters (76.2%) of participants expressed about it is crucial for family members to remain at the bedside until death occurs. Details are depicted in table 1.

Regarding the domains of PCQN, philosophy, and principles of PCQN had mean±SD of 1.38±0.98 (range=0-4), management of pain / other symptoms domain had mean±SD of 7.18±1.66 (range=3-11) and in psychological aspects of care mean ±SD was 1.25±0.50 (range=0-2).

As regard to attitude as measured by "Frommelt Attitude toward the Care of the Dying Scale (FATCOD)", three quarters (76.2%) of participants affirmed that giving care to the dying person was worthwhile to experience. Nearly two-thirds (68.9%) of participants agreed that they would be uncomfortable talking about impending death with the dying person. Most (92.6%) of participants accepted that caring for the patient's family should continue throughout grief and bereavement. More than half (60.7%) of participants strongly disagreed that they would not want to care for a dying person. Two-thirds (69.6%) of the participants disagreed that the length of time required to care for a dying person frustrated them. One-third (32.8%) of participants agreed that it was difficult to form a close relationship with the dying person. A majority (80.3%) of participants affirmed that there were times when death was welcomed by the dying person. Two-thirds (66.4%) of participants thought that it is best to change the subject to something cheerful when a patient asked about their dying. The majority (86%) of the participants acknowledged that families need emotional support accepting the behavioral changes in the dying person. When participants were inquired if the dying person should be allowed to decide on their physical care, 55.7% of them agreed. Most (90%) of the participants accepted that families should maintain a normal environment for their dying members. A majority (82.6%) of the participants agreed that dying persons need to be provided with flexible visiting schedules by the caregivers. There was an agreement seen in 68.1% of participants that they felt uncomfortable entering the room of a terminally ill person who was crying. The mean score of different domains is depicted in table 2.

A majority (70.5%) of participants had a poor level of knowledge whereas, 71.3% had a fair attitude which is presented in table 3.

Table 2. Mean score of participants' atitude based on FATCOD questionnaire (n=122).

Characteristics	**Items**	**Score range**	**Mean ± SD**
Cognitive domain	12	27 - 52	42.01 ± 4.23
Affective domain	9	18 - 42	29.95 ± 4.31
Family-related domain	9	22 - 42	30.67 ± 3.56

Table 3. Level of knowledge and attitude of participants (n=122).

Characteristics		**N (%)**	**Range**	**Mean ± SD**
Knowledge	Poor	86 (70.5)	4-14	8.82 ± 1.95
	Fair	36 (29.5)		
Attitude	Fair	87 (71.3)	88-142	107.36 ± 9.17
	Good	35 (28.7)		

On analysis with Pearson Correlation test, there was a negligible correlation between the level of knowledge and attitude which was not statistically significant (r = 0.135, p = 0.887).

Ethnicity and religion was statistically significant with level of knowledge(χ^2=5.736, df=1, p=0.03). Whereas, cared for dying relatives was found statistically significant with the level of attitude (χ^2=5.146, df=1, p=0.03).

DISCUSSION:

The study aimed to find out the nurses' knowledge and attitude on palliative care. The present study revealed that the majority of nurses had a poor level of knowledge which is similar to the studies conducted in Congo and Egypt.[6,11] But it contrasted with other studies which showed a comparatively good level of knowledge.[4,12,13] The possible reason for variation may be that those participants had received palliative care training, had exposure in palliative care unit as well as higher working experience. The overall mean score of knowledge of PCQN in this study was 8.82 which is consistent with other studies.[3,11,13] The present study reported a lower mean score (1.25±0.50) in the psychological aspects of care. The possible reason may be, in our context, we are not giving much importance to mental health as compared to physical health.

The study revealed that 64.8% of participants think palliative care is appropriate for terminally ill patients or at end-of-life care. This is similar to the studies conducted in Ethiopia.[4,8] From this inference can be drawn that, palliative care is still viewed as care offered only for dying patient or patient who have no chances of improvement. Likewise, many (86.1%) participants believed that the extent of the disease determines the method of pain management which is similar to the studies conducted in Ethiopia and Congo.[4,6] But the fact is that the severity of the pain determines the method of pain management not by the extent of disease. As none of the participants had ever attended training related to palliative care might be the possible reason for giving such an answer.

In the present study, most of the participants expressed that drug addiction is the major problem when morphine is used for a prolonged period of pain management which is similar to other studies' findings.[4,8] Drug addiction is not a major problem in dying patients other than pain management. The possible reason for this might be a lack of exposure and training on palliative care for nurses. A maximum (90.2%) number of participants also reported that adjuvant therapies are important in managing pain. This finding is comparable with other studies as well.[3,4,6,8] In the present study, 76.2% of participants acknowledged that family members must remain at the bedside until the death of the patient. Similarly, 89.3% of participants reported that men generally reconcile their grief more quickly than women but the contradictory finding was reported by another study.[3] The possible reason may be the cultural and value system differences in both countries.

This study revealed that 71.3% of the participants had a fair attitude towards care of the dying patient and these consistent results have also been found in other studies.[3,4,6,8,11,13,14] The mean score of attitude was 107.36 in this study which is consistent with the findings of other studies.[3,13,15]

This study stated that 76.1% of nurses agreed that giving care to the dying person is a worthwhile experience. A similar opinion has been reported in other studies as well.[3,4,6,8,11] Likewise, 68.9% of the participants expressed that they would be uncomfortable talking about impending death with the dying person and a similar opinion has been told by the nurses in some other studies.[6,11] But the contradictory finding was found in other studies.[4,8,13] Possible reason for differences in opinion may be the disparity in cultural values and norms. The study documented that, 92.6% of participants agreed about extending care to the patient's family throughout grief and bereavement and similar opinions were also expressed in other studies.[3,8,12,11] Present study reported that 66.4% of the nurses agreed to change the topic to something cheerful when the dying person asked if he/she was dying. Similar expressions were found in other studies as well.[3,6,8,11] Expressing or talking about negative outcomes to the patient himself could be a bitter experience which nurses may be tended to remain aloof. The majority of nurses opined that the dying person and his or her family should be the in-charge decision-makers which is akin to other studies.[3,6,8,11] This will indicate that nurses respect patient's bill of rights.

The present study revealed that there is a statistically significant relationship between religion and ethnicity with the level of knowledge. The culture molds the behavior and the belief systems of an individual which could be a possible reason for the relationship. Similarly, the experience of care for dying family and close relatives have found statistically significant with attitude towards the care of dying which is concurrent with the findings of another study.[13] But the findings of other studies showed that working area, working in the palliative care unit, training in palliative care, education level, and experience were found statistically significant with knowledge and attitude level.[3,4,8,12,13] Possible reason for differences in findings might be that the participants of this study were aloof from formal training and had no or minimal experience of working in a palliative care unit. The study prevailed correlation between knowledge and attitude which is similar to the finding of a study conducted in India.[15]

The study is not exclusive of limitations. Limited clinical experience of nurses', lack of exposure to separate palliative care units, no provision of formal training, and in-service education regarding palliative care so far might be the possible reason for lack of knowledge. Thus, the result cannot be generalized.

CONCLUSION:

Nurses' knowledge regarding palliative care was found poor, but they had a fair attitude in dealing with the patient who requires palliative care. The psychological aspect of care knowledge seems very poor. In the attitude aspect, nurses were feeling very reluctant to deal with or discuss negative outcomes with the patient themselves. Training and regular in-service education for nurses can enhance their knowledge level. Provision of positive reinforcement, appreciation, and rewards for desirable behavior could help nurses to develop a positive attitude towards palliative care.

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Conflict of Interest:

The authors declare that no competing interests exist.

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