

## Knowledge and Caring Attitude of Sri Lankan Nurses in Providing Care for Dying Patients — A Cohort Study

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This research identified evidence of knowledge and caring attitude among Sri Lankan nurses caring for dying patients; and identified the factors affecting nursing care for the dying in the eastern province of Sri Lanka.

A quantitative cohort study design was used having questionnaires as the means of collecting the data. The purposive way of sampling selected 120 staff nurses employed in a government hospital as respondents who falls under the inclusion and exclusion criteria.

There was significant evidence of caring attitude towards the dying ( $p = 0.005534$ ) and knowledge on the end-of-life nursing care ( $p = 0.0004703$ ) for the dying patients. Educational attainment ( $p = 0.050001$ ), clinical experiences ( $p = 0.01499$ ), age ( $p = 0.01061$ ) and civil status ( $p = 0.001782$ ) were factors affecting the knowledge and attitude of Sri Lankan nurses in delivering nursing care for the dying patients admitted to a government hospital.

**Key words:** Cohort study; observational study; nursing; knowledge and caring; dying patients; end-of-life care

This research observes the knowledge and caring attitude of Sri Lankan nurses in providing nursing care for the dying patients in a government hospital. Palliative care for the dying and the quality of life of patients are issues in healthcare in Sri Lanka (McKeown *et al.* 2010). When the prognosis for the patient was imminent death, care was focused on reducing the severity of the disease symptoms rather than vainly trying to stop or delay development of the illness itself or providing a cure (Kinder & Ellershaw 2003, p.12).

The delivery of similar quality end-of-life

care to patients in most Sri Lankan hospital foundations was developed by the Base Hospital Hospice Friendly (BHF) programme that respects the curative model of attention but ensures that the quality of life for the dying patients (BHF 2010).

Therefore, the purpose of this research is to recommend quality standards for end-of-life care in a government hospital in consultation with hospital staff and professional bodies to set out a vision for the type of end-of-life care that all Sri Lankan hospitals should aim to provide. The Liverpool Care Pathway

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(LCP) for the dying patients will also be acknowledged in the recommendation section after a conclusion is offered. The LCP is an inter-professional documented care pathway that provides guidance on the different aspects of care required, including comfort measures, anticipatory prescribing of medication and discontinuation of inappropriate interventions (Kinder & Ellershaw 2003); and frequent monitored outcomes of care in the last days of the patient's life (Walker & Read 2010).

### RESEARCH PROBLEM

Health Service Executive (2009) says that the influences of the nursing approach in delivering end-of-life nursing care is deteriorating. It is similar in the Sri Lankan set up where the nurses' knowledge and caring attitude was slowly disappearing, as influenced by the medical and non-nursing models in government hospitals. There was a need in Sri Lanka to develop a pathway that is a research-based plan to establish a recommendation for end-of-life care.

### Variables

The cause variable is the knowledge and caring attitude of nurses while the effect variable is the provision of end-of-life care (using the LCP) given to dying patients. The variables will then answer the question: do Sri Lankan nurses have the knowledge and caring attitude in providing care for the dying patients?

### Aims

At the end of this research, it is hoped to:

1. Identify evidence of knowledge and caring attitude among Sri Lankan nurses caring for dying patients.
2. Determine factors affecting end-of-life nursing care in the eastern province of Sri Lanka.

### Hypothesis

There is a significant evidence of knowledge and caring attitude among nurses caring for the dying patients.

### Literature Review

Search engines were Google Scholars and Cumulative Indexes for Nursing and Allied Health Literatures having 20 000 numbers of hits using key words such as "*Nursing, knowledge and caring, dying patients, end-of-life care*". The thematic system of reviewing literature divided this section into three themes. The literature review will be divided into:

- (i) Identification of the dying phase – describes the knowledge and caring attitude
- (ii) Comfort Care – describes the caring attitude alone
- (iii) Symptoms Control – describes the knowledge alone

### Identification of the Dying Phase

The unpredictability of hematological malignancies, hormones shutting down and degeneration of hydration and nutrition are primary in identifying the dying phase (Preston 2007; McKeown *et al.* 2010). Furthermore, pain, nausea, vomiting, agitation and respiratory tract secretions are among the most usual symptoms to be identified in the dying phase (Glare *et al.* 2003; Toscani *et al.* 2005, Gambles *et al.* 2006; Lhussier *et al.* 2007). Failure to identify that a patient is dying affects the quality of end-of-life care they receive (Thompson *et al.* 2006; Dalgaard *et al.* 2010).

In a qualitative study of terminal illness stages, Dalgaard *et al.* (2010) found that it was important to identify the terminal phase progression towards death. The research

approach observed various staff functions and conducting informal interviews with patients (n = 74), relatives (n = 11), doctors and nurses in a haematology department in Denmark. The unpredictability of hematological malignancies, patients' and relatives' lack of acceptance of impending death and their investment of hope in further treatment, were found to hinder doctors in formally identifying the terminal phase. Nurses reported poor inter-professional cooperation, caused by doctors focusing on treatment and cure, while nurses gave priority to the patient's general condition. Dalgaard *et al.* (2010) concluded that open communication with all concerned in decision-making was essential in the transition to the terminal phase.

The qualitative study on the delivery of palliative care in an intensive care unit (ICU) in Ireland was conducted by McKeown *et al.* (2010) also examined the difficulty of identifying the terminal phase, using a grounded theory interview-based approach. The volunteer sample comprised of ten nurses, five consultants, and ten junior medical staff. Nurses reported that dying patients were treated aggressively for too long with a focus on cure instead of palliative care. Doctors stated that they were responsible for deciding when to cease curative care and begin palliative care, but many preferred to wait for visible signs that the patient had deteriorated rather than intervene. Nurses felt they had a more accurate view of their patients' conditions, but they found it difficult to get the doctors to accept this. McKeown *et al.* (2010) suggested that multidisciplinary team education on palliative care would improve confidence in decision-making in end-of-life care issues. While it is recommended in this study that education on end-of-life care was needed there was no actual identification for the dying phase.

A qualitative study conducted by Walker and Read (2010) on identifying the terminal phase in an ICU in the United Kingdom in the northwest Midlands using the LCP. The LCP is commenced on the presence of two out of the following four criteria: "the patient is bed-bound, semi-comatose, and only able to take sips of fluid or no longer able to take tablets." A purposive convenience sample of doctors (n = 1) and nurses (n = 5) who had used the LCP was interviewed in a descriptive phenomenology study. It was considered that when end-of-life decisions were made the doctor made the decision and care of the patient was then handed over to nurses. Some nurses felt that the weight of responsibility made end-of-life decision-making difficult for physicians. The nurse felt their education was adequate, but doctors and nurses both felt that teaching in this field could not identify the terminal phase. Walker & Read (2010) concluded that there was a need for interdisciplinary educational strategies on end-of-life care in the ICU to determine the terminal phase.

*Comfort care.* Movement of the patient in the final days of life and assisting in the daily activities are measurements of comfort care (Thompson *et al.* 2008; McKeown *et al.* 2010).

McKeown *et al.* (2010) stated that when patients have been diagnosed as dying, their care goals should be adjusted to comfort care. Research studies on the care of the dying patient were reviewed under the above headings to investigate the approaches to the delivery of this care. Comfort care of the dying by McKeown *et al.* (2010) noted that the development of standards for end-of-life care that was important as almost 50% of Irish died in hospitals. In this research, it draws the conclusion that comfort care of the dying "tends to be generic rather

than specific in the sense that it might be more appropriate to describe it as 'care at the end of life' rather than 'end-of-life care', because the care seems to lack an effective palliative care component" (McKeown K. *et al.* 2010, p.158).

A less satisfactory experience on the delivery of comfort care was found by Thompson *et al.* (2008) in a qualitative study using a grounded theory approach to examine the transition of attention from curative to palliative. Semi-structured interviews were conducted on a convenience sample of nurses (n = 10) from two hospitals. Nurses perceived that physicians hesitated to switch to end-of-life care measures because they viewed commencing palliative care as doing nothing for the patient. The nursing staff was frustrated that the over-emphasis on the curative model impacted on their ability to deliver comfort care as they were required to perform unnecessary procedures rather than care holistically for the patient. Thompson *et al.* (2008) concluded from the research evidence that it is essential that all parties acknowledge the fact that cure of the disease is not possible before the establishment of an appropriate end-of-life care plan is based on the patient's needs.

Similar barriers to delivering optimal terminal comfort care were found in a qualitative study conducted by Espinosa *et al.* (2010) in the United States of America on ICU nurses' experiences. A descriptive phenomenological study using a purposive sample of ICU nurses (n = 18) was conducted by holding focus group interviews on previously identified themes. As in the study conducted by Thompson *et al.* (2008), it was found that nurses considered that the different perspectives in medical and nursing care presented a problem for their delivery of comfort care to the dying patient.

Nurses who were trying to achieve a peaceful end-of-life for the patients found it difficult to deliver care ordered by physicians when it had no apparent benefit at all. Relatives' unrealistic expectations that everything possible is done for the patient was also a barrier to delivery of end-of-life care. Based on the study it was concluded that nurses needed education and training on delivering terminal care and that knowledge by observation was not sufficient. Espinosa *et al.* (2010) also recommended that research is conducted on methods to improve communication between the different professionals involved in end-of-life care.

*Symptoms control.* The symptoms that need to be controlled are dehydration, pain, nausea, vomiting, agitation and respiratory tract secretions among the dying patients (Glare *et al.* 2003; Toscani *et al.* 2005, Gambles *et al.* 2006; Lhussier *et al.* 2007). However, palliative care among professionals felt that a dry mouth for a dying patient did not indicate thirst but a good mouth care was more appropriate than medical hydration (Preston 2007).

Toscani *et al.* (2005) conducted a qualitative study on symptom control in hospitals by collecting data from clinical records and interviewing the nurses in charge of dying patients (n = 370) in 40 Italian hospitals. They found that a substantial proportion of dying patients received inadequate symptom control (75%) and inadequate pain relief (40%). Dying patients also suffered distressing symptoms such as nausea, vomiting, insomnia and anorexia. It was found that nurses assessed the overall management of the patient as good/excellent in 88% of cases despite the presence of uncontrolled symptoms. Toscani *et al.* (2005) considered that pain and symptom control was poor in these hospitals and resources should be provided to improve end-of-life care and educate healthcare professionals.

Gambles *et al.* (2006) conducted a qualitative survey of doctors' and nurses' perceptions of comfort care in Sri Lanka using exploratory interviews. The purposive sample comprised of nurses (n = 8) and physicians (n = 3). Doctors felt that patients had better symptom control with the use of the LCP, as signs were picked up and addressed earlier. They felt that good care and symptom control contributed to a good death. Nurses reported that the LCP made it clear to inexperienced staff what they could expect when looking after a dying patient making them more pro-active and consistent (Gambles *et al.* 2006). Gambles *et al.* (2006) recommended that continued education was necessary with the use of the LCP.

With a view to developing good quality end-of-life symptom control care, the LCP was introduced in a volunteer sample of nursing homes (n = 8) in Northwest of England (Watson *et al.* 2006). Over a 12 month period, using an action research approach involving field notes and questionnaires it was found that there was a lack of control of end-of-life symptoms due to poor knowledge of palliative care drugs among staff (Watson *et al.* 2006). From patient notes, it was found that loss of swallowing reflex was seldom noted for dying patients and as a result, subcutaneous or rectal medication was rarely prescribed to circumvent the problem. Watson *et al.* (2006) viewed anticipatory prescribing of the necessary drugs for symptoms that might arise as being necessary for end-of-life care. They also concluded from their research that collaborative learning groups are useful for sustaining change in practice in end-of-life care.

Similarly, Lhussier *et al.* (2007) conducted a qualitative evaluation using action research methodology in two Primary Care Trusts

in Sri Lanka with a view of the LCP for symptom control. The volunteer sample of participants comprised of LCP facilitators (n = 10), professionals implementing the LCP (n = 22) and bereaved carers (n = 10). Experts felt that the LCP enabled them to pinpoint symptom problems and address them before they became too dangerous for the patient. One respondent commented that the LCP made staff more pro-active in controlling symptoms. Some criticism of the LCP model of care was expressed as it was felt that its 'tick box' approach resulted moved the focus from the symptom control needed by the dying patient. However, Lhussier *et al.* (2007) concluded that overall the implementation of the LCP had met several challenges in end-of-life care and they considered that symptom control should be given a higher profile on the professional agenda.

*Analysis of the review.* Most of the researchers on the reviewed literature are qualitatively designed although appropriate. Also, no research in Sri Lanka was yet done to evaluate the effectiveness of an end-of-life care by nurses. It would also be more interesting to observe a mathematical expression of the knowledge and caring attitude of Sri Lankan nurses in caring for the dying. The variables — identification of the terminal phase, comfort care, and symptom control — would then be numerically expressed that measured knowledge and attitude of nurses in end-of-life care.

*Methodology.* This section will describe the design, sampling technique, data collection and the how data are analyzed. Ethics on how this research commenced will also be discussed.

## RESEARCH DESIGN

A cohort quantitative study design was hence appropriate since the respondents answering the questionnaires only came from one group that organizes in advance the research question and a one-way method of data collection (Parahoo 2006; Polit & Beck 2010; Robson 2007). A detailed design involving a survey, as outlined by LoBiondo-Wood & Haber (2006), was chosen for this study. Quantitative design should be objective, systematic and repeatable (Proctor *et al.* 2010).

*Population/sampling technique.* The samples in this study were staff nurses working in a cohort — a government hospital in Sri Lanka. Purposive sampling technique will form the target group. This population will be delimited to a homogenous group of subjects through inclusion/exclusion criteria (LoBiondo-Wood & Haber 2006; Proctor *et al.* 2010).

*Inclusion criteria.* Registered general staff nurses who worked at Pottuvil Base hospital were chosen as the target population. Only nurses caring for adult patients in the end-of-life care were purposively included. Nurses who had served more than one year in the ward were individually selected. The researcher obtained the names of all qualified nurses from the Human Resources Department in the hospital. This list of nurses formed the sample frame from which the researcher selected.

*Exclusion criteria.* Registered nurses working with children were excluded. Nurses who had already tendered their resignation or have filed their retirement were also excluded to limit biases. Biases might also occur if the nurse respondents had come from the private hospitals outside Sri Lankan territory, and who were newly hired from the particular government hospital selected were excluded. Lastly, nurse respondents who had admitted their relatives, and loved ones in the said government hospital also were excluded.

## Sample Size

In quantitative research, the size of the sample should be calculated at the design stage (Proctor *et al.* 2010). Parahoo (2006, p. 258) defines a sample population as “the total number of units from which data can potentially be collected.” According to Polit and Beck (2010), quantitative researchers should select the largest sample possible so that it is representative of the target population. For this reason, it was proposed that a sample size of 120 nurses be used for the study.

The calculations used to get the population was:

$$\begin{aligned} \Sigma & \text{— Sum of values} \\ \mu & \text{— Mean estimate} \\ \sigma & \text{— Standard deviation} \\ n & \text{— Prevalence} \\ x & \text{— Total} \\ \sigma & = \frac{\sqrt{\Sigma (x-\mu)^2}}{n} \end{aligned}$$

## Data Collection

Robson (2007) says that a researcher should use the simplest manner of collecting the data to get answers from the research question and should not collect any more data than necessary. A questionnaire is a method of data collection that asks participants to give written or verbal replies to a written set of questions (Parahoo 2006). It is a quick, convenient and inexpensive method of collecting standardized information (Jones & Rattray 2010). A structured written questionnaire that uses a quantitative self-report technique was used to gather data in this study.

A Likert-type scale will be used in the questionnaire to gather data. According to Parahoo (2006) a Likert-type questionnaire formulates statements which the researcher considers that will represent the concept being measured without going through the validation process.

Part A consisted of positively and negatively worded statements with six different response options ranging from ‘strongly disagree’ to ‘strongly agree’, with the knowledge on identification of the terminal phase, comfort care, and symptom control. Positive statements are scored one to two (‘agrees’, and ‘disagrees’), and scores are reversed for negative statements. The score for each item will be reported individually. Parts B and C will be caring attitudes that used a fill the box format and will gather data divided into frequencies.

*Validity of the questionnaire.* Face validity checks that the sampling seems to measure the concept being tested (LoBiondo-Wood & Haber 2010) and this will be assessed by a pilot study to test-run the instrument and see if the questions appear to be relevant, clear and unambiguous ( Jones & Rattray 2010).

A panel of experts was used to evaluate the content validity of new questionnaires (Polit & Beck 2010). The questionnaire would be submitted to a panel to check that the questions reflected the concepts being studied and that the scope of the questions was adequate, in the manner proposed (LoBiondo-Wood & Haber 2010). The panels were qualified in end-of-life care with research experiences on the topic.

*Reliability of the questionnaire.* The researchers did a stability test using the test-retest method on a small population. The questionnaire was administered on two occasions, two weeks apart and the results compared. A reliability coefficient was calculated on the two sets of data for each part of the questionnaire. Reliability coefficients ranged from 0.00 to 1.00, with higher values indicating greater reliability. According to Jones and Rattray (2010), good reliability is indicated by a coefficient  $>0.8$ , so the researcher will attempt to achieve a liability at this level or greater (Polit & Beck 2010). The ‘test-retest’ will be included in the pilot study. However, according to Parahoo (2006)

reliability is necessary but not a sufficient condition for validity but rather focuses mainly on stability and consistency (Polit & Beck 2010).

### Data Analysis

The questionnaire was split into three equal halves, and the data was checked for similarity. Consistency would be checked by Cronbach’s alpha ranging between 0.00 and 1.00, and a value of  $>0.7$  is acceptable (Polit & Beck 2010).

Central tendencies were be carried out on the data collected. Analysis of part A of the questionnaire was coded using numbers on an ordinal scale of 1 to 6. The Central tendency of the data was calculated using the mode (most frequent response) for Part A as the data was represented by ordinal numbers. Numbers on an ordinal scale are in ascending order, with no same steps implied between the numbers. The reply to each question of Parts B and C of the questionnaire will be coded using numbers in the ordinary sense. For Part B and Part C central tendency will be calculated by calculating the mean response and the standard distribution around the mean. The frequency of a particular response to a question was calculated as a percentage, and the data was illustrated using tables and bar charts.

To check on possible connections between variables, inferential statistics were used (Parahoo 2006). Correlations were verified between (i) data on participants’ nursing experience in the number of years, and (ii) participant’s education in end-of-life care. Contingency tables were set up to cross tabulate the above variables. Correlation coefficients would check the intensity and direction of the correlations. The values of these coefficients ranged from  $+1.00$  for a positive relationship through 0.00 to  $-1.00$  for a negative correlation.

## Pilot Study

The validity and reliability of the questionnaire was also checked at the pilot study stage (Jones & Rattray 2010). As recommended by Robson (2007) the researcher to run a trial test on the selected method of data analysis could use the data collected in the pilot study to generate dummy data for 120 participants.

A pilot study was carried out using a small sample of subjects,  $\geq 10\%$  of the principal study ( Jones & Rattray 2010; Proctor *et al.* 2010; Polit & Beck 2010). Twenty-three subjects were chosen in the same manner as the topics for the main study. The pilot participants were debriefed to check for problems with the questionnaire and issues concerning it. The structure and content of the questionnaire was amended accordingly. Care was taken that the participants in the pilot study were excluded from the main study and that details of the study were not passed on to main study participants.

## Ethics

Ethical considerations for this particular research study started with the Lincoln University College, Faculty of Nursing approval. It was then shown to the Research Committee of the University for approval. Written consent was also secured. Hospital Approval was also sought, and a letter of approval from the selected hospital was granted.

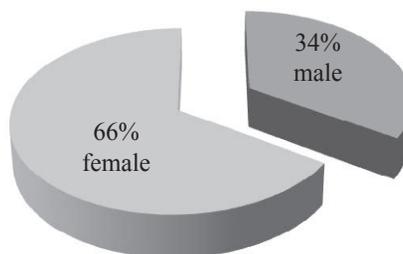
It is hoped that the chosen methodology will generate useful information through the collection and analysis of data on the attitude, and knowledge of staff nurses on the effect of care for the dying patient in a government hospital in the eastern province of Sri Lanka.

According to Polit and Beck (2010), researchers must deal with ethical issues when their proposed research involves human beings. As a gatekeeper, the Director of Nursing must be made aware of all nursing research taking place in the organization to monitor the effect of all such projects taking place.

The main ethical principles that were considered in conducting this research study was respect for persons, confidentiality and beneficence/non-maleficence.

## FINDINGS AND RESULTS

Of the 123 nurses as respondents, 66% were female, and 34% were male (*Figure 1*). It is interesting to identify that the nursing profession is always associated with the female gender. However, gender differences were not correlated with the caring attitude and knowledge on nursing care towards the dying patients admitted to the selected government hospital.



*Figure 1. Gender distribution.*

The educational attainment (*Figure 2*) was identified to have affected the caring attitude and knowledge of caring for the dying patients. There were more diploma holders (94%) as compared to the bachelor's degree (6%) and masters (0%). Symptom control identified knowledge while comfort care identified the caring attitude and identification of the dying phase identified both knowledge and caring attitude — all of which were affected by the educational attainment of the respondents.

*Figure 2* identifies the prevalence of the Sri Lankan nurses that had no master's degree and a limited number of bachelor's degree holder. The results showed that the higher the education the nurses attained, the better the delivery of nursing care for the dying patients which correlated with their knowledge and attitude.

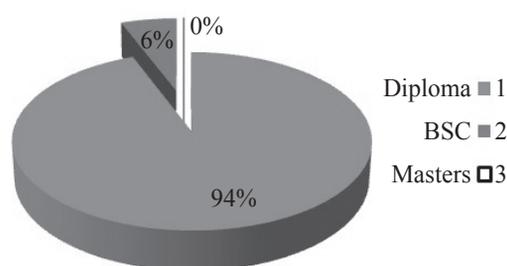


Figure 2. Educational Attainment.

Aside from the educational attainment ( $p = 0.050001$ ) of Sri Lankan nurses caring for the dying, it was also identified that their clinical experiences ( $p = 0.01499$ ), age ( $p = 0.01061$ ) and civil status ( $p = 0.001782$ ) were more probable to have affected their caring attitude and knowledge (Table 1).

The civil status showed a high standard deviation ( $\sigma$ ) of 25 from the mean ( $\mu$ ) of 60. This result identified a good compliance to nursing

care for the dying patients. Specifically, those who were married had more caring attitude and knowledge of nursing care.

The age was the second factor that was more probable to have affected the caring attitude and knowledge of the Sri Lankan nurses. Nurses who were ages 25 to 40 years old were more probable ( $p \leq 0.05$ ) than those who were 40 to 50 years old ( $p \geq 0.05$ ) in delivering nursing care for the dying.

The experience however was still probable even though the deviation ( $\sigma = 15$ ) was nearer to the mean ( $\mu = 24$ ) as compared with the age group. Experiences from 1 to 20 years in the nursing service identified a higher probability ( $p \leq 0.05$ ) of delivering nursing care with knowledge and attitude for the dying patients. On the other hand, 21 to 30 years of experience had the least probability ( $p \geq 0.05$ ).

Table 1. Factors affecting knowledge and attitude.

	Probability	N
Experience 1 to 5years	$\leq 0.05$	36
Experience 5 to 10years	$\leq 0.05$	43
Experience 10 to 15years	$\leq 0.05$	27
Experience 15 to 20years	$\leq 0.05$	12
	$\geq 0.05$	2
Total	0.01499	$\mu = 24$ $\sigma = 15$
Age 25 to 30	$\leq 0.05$	34
Age 30 to 35	$\leq 0.05$	36
Age 35 to 40	$\leq 0.05$	33
Age 40 to 45	$\geq 0.05$	10
Age 45 to 50	$\geq 0.05$	7
Total	0.01061	$\mu = 24$ $\sigma = 13$
Civil status (married)	$\leq 0.05$	85
Civil status (unmarried)	$\geq 0.05$	35
Total	0.001782	$\mu = 60$ $\sigma = 25$

It was evident that the respondents were aware of the LCP code of practice on providing a caring attitude towards the dying. One of the negative practices which the LCP measured were the “No respond attitude” (n = 104) and the “negative feelings towards providing care” (n = 69) which the respondents agreed to deliver. However, there were more respondents who agreed on delivering comfort care (n = 108) and adapted focus care (n = 103) and routinely providing care (n=100) saturating the populations. Besides, giving honest and genuine answers (n = 99) and routine care before death (n = 90) were also important.

The LCP code of practice on the knowledge on end-of-life nursing care starts with the patient safety (n = 107) which a lot of respondent nurses agreed to have delivered followed by respect for

patient’s decision towards the care to be given to them or the decision to end their life such as mercy killing (n = 99). Treatment modalities (n = 104), reassessing current medications (n = 04), medicating patients (n = 119), and symptoms control (n = 20) were also identified together with the routine nursing practice (n = 105) which were more of the physiologic needs of the dying patients.

It was worth noting to identify evidence of caring attitude towards the dying (p = 0.005534) and knowledge on the end-of-life nursing care (p = 0.0004703) to be probably among Sri Lankans.

*Tables 2 and 3* identify the specific knowledge and caring attitude of Sri Lankan nurses to the dying patients.

Table 2. Caring attitude towards the dying.

Caring attitude towards the dying	N	%
No response attitude	104	84.6
Routine care	100	81.8
Spending personal time	89	72.4
Giving honest and genuine answers	99	80.5
Routine care before death	90	73.2
Adapted focus of care	103	83.7
Comfort care	108	87.8
Negative feelings towards providing care	69	56.1
Mean	60	
Standard deviation	36	
Probability	0.005534	

Table 3. Knowledge on end-of-life nursing care.

Knowledge on end-of-life nursing care	N	%
Patient safety	107	87
Respect for patient's autonomy	99	80.5
Treatment modalities	104	84.6
Routine nursing practice	105	85.4
Identification of the dying phase	65	55.8
Re-assessing current medication	104	84.6
Medication	119	96.7
Symptoms control	20	16.3
Mean	90	
Standard deviation	32	
Probability	0.0004703	

## DISCUSSION

In this section all aspects of the research process including the results, limitations, and benefits, will be discussed.

The nurses' attitude and knowledge in caring for the dying were identified through education, age bracket, civil status and clinical experiences. This revealed other factors such as gender impact that was also useful in the delivery of care for the dying patients.

Primarily, this study was reliable however limited to only one government hospital. Also, only the LCP was the primary guideline that was used in this selected government hospital. It was acknowledged that there were other guidelines in caring for the dying, however; it was not used to indicate a weakness on this research.

Secondly, the questionnaire revealed some disagreement between nurses about newly admitted patients on their dying phase since the LCP guideline was limited to long-term care and not for the acute. This study showed the need for professional consensus among newly admitted patients who were dying before appropriate end-of-life care was initiated. Some studies found that even when the patient was identified as dying, their primary physicians still continued with diagnostic and therapeutic interventions and nurses who wished to deliver care focused only on comfort care and symptom control. This is why studies found on the literature review on the use of the LCP found that clinical experiences and educational attainment contributed to the successful delivery of comfort care for the dying. Therefore healthcare professionals' education level in end-of-life care was noted in the result section.

Lastly, euthanasia was not included in the aims of this study although it could also contribute to the identification of knowledge and caring attitude. Euthanasia or respecting autonomy for the dying patient to decide to end their life was a part of the guideline of the LCP and would require a special research process which this study did not identify.

The strength of the results, however, quantitatively contributed to recommendations in future nursing practice, nurse education and research. Unlike other qualitative studies, this study moved palliative care higher up on the agenda of the nursing profession in Sri Lanka.

### CONCLUSION

There was significant evidence of caring attitude towards the dying ( $p = 0.005534$ ) and knowledge on the end-of-life nursing care ( $p = 0.0004703$ ) for the dying patients. It was also concluded that educational attainment ( $p = 0.050001$ ), clinical experiences ( $p = 0.01499$ ), age ( $p = 0.01061$ ) and civil status ( $p = 0.001782$ ) were some factors affecting the knowledge and attitude of Sri Lankan nurses in delivering nursing care for the dying patients admitted to a government hospital.

### RECOMMENDATIONS

The researcher recommends that Sri Lankan cities do more studies in the end-of-life nursing care. It is the intention of the researcher to share the findings of the study with the management of the selected government hospital and to the Sri Lankan schools of nursing and midwifery. It is hoped that this will highlight the necessity of planning on-going education and training for nurses in end-of-life nursing care.

To present this research to a broader audience, the researchers intend to apply the study's recommended code of nursing practice on:

- (1) Attitude — empathetic response to patients, routine nursing care, spending personal time, giving honest answers when asked about their conditions, routine care before death, adapted focus of care, comfort care, and their feelings manifested through gestures when providing care to the dying patients; and
- (2) Knowledge — understand treatment modalities to ensure patient safety, respect for patient's decisions, routine nursing practice, re-assessing current medications, and identification of the terminal phase and symptoms control.

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