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Abstract

The aim of this study was to explore the lived experience of nurses in providing comfort to palliative care patients in an acute setting. A qualitative approach using Gadamerian hermeneutic phenomenology was chosen for the study and data was collected using open interviewing. The main findings revealed four major themes (with sub themes) that describe the lived experience of providing comfort to palliative care patients in an acute setting: time needed to provide comfort, emotional cost to the nurse in providing comfort, a holistic approach in the provision of comfort and the role of education and the expert team in providing comfort. The study findings will contribute to a greater understanding of the difficulties and challenges that general non-specialised nurses in the acute setting have in trying to understand and apply the philosophy of palliative care to patients in an acute care setting. The findings should also contribute to a broader appreciation between specialised and non-specialised nurses who are both responsible for the delivery of holistic individual person centred focused care to patients requiring palliative care.

Key words: comfort, palliative care, acute care, phenomenology

Introduction

This study explored the phenomenon of nurses providing comfort to patients receiving palliative care in an acute setting. There is no uniform definition of comfort in the literature (Tutton and Seers, 2004) and accordingly definitions are diverse and drawn from different perspectives. However, the definition of comfort proposed by Kolcaba (1992, 1994) was considered most appropriate here. Kolcaba suggests that comfort is concerned with meeting needs by nursing actions that bring relief, ease and transcendence.

Providing comfort is viewed as the major instrument for care in the clinical setting (Morse, 1983). However, comfort is often under-valued (Hendrick et al, 1996). This could be because comforting strategies are integrated into nursing routine and care activities and therefore are taken for granted by nurses themselves (Bottoroff et al, 1995). Moreover, the acute hospital setting is cure-orientated, high-tech, dramatic and fast-paced and these aspects may result in the provision of comfort being rendered unrecognised and/or unacknowledged.

Methodology

Gadamerian hermeneutic phenomenology was adopted to guide the study methodology. Gadamer's hermeneutic philosophy offers a potential framework to guide nurses through the process of research, thus facilitating nurses to develop knowledge associated with the 'how' and 'art' of nursing (Pascoe, 1996). Its aim is the translation and understanding of the lived experience into a recognisable meaning that can then be utilised as a knowledge base in nursing practice (Van der Zalm and Bergum, 2000). Research undertaken and guided by the philosophy of Gadamer asserts that the researcher's pre-understandings and prejudices form part of the research data and are not bracketed out. Gadamer (2004) contests that elimination of prejudices is not only impossible, it is also unnecessary. He supports this argument by stating that its absence can interfere with the interpretation process.

Reflexivity is an essential aspect of interpretive research. This is achieved through writing, analysing, reflecting and rewriting (Alvesson and Skolberg, 2000; Dowling, 2006). A reflexive journal was therefore kept throughout the duration of the study.

Ethical approval for this study was obtained from the Ethical Committee of the hospital where the study was undertaken. All study participants were provided with written participant information two weeks before being interviewed. Anonymity and confidentiality was assured through the use of pseudonyms and interviewing in a private area.

The sample was purposefully chosen from nurses working in one acute hospital. Seventeen nurses (all female) with experience of caring for palliative care patients in

an acute hospital volunteered in response to a memo displayed in the clinical area inviting participants. Four declined later for personal reasons and one nurse's interview was a pilot; therefore twelve interviews were used for data in the study. Nurses interviewed had between 7 to 40 years' experience. It is important to point out that providing comfort in the context of caring is viewed as intersubjective and feminine (Noddings, 1984). All the study participants were female, and therefore, the meaning of providing comfort explicated in this study is gender context.

All of the interviews took place between February and March 2008 and were audio taped and transcribed verbatim. The approach was a non-directive open style of interviewing as advised by van Manen (1990), with each interview built around the participant's response to the question: "Tell me of your experience of providing comfort to palliative care patients on an acute ward". Interview length varied in time from 20 minutes to 70 minutes and no attempt was made to shorten or prolong these interviews allowing the interviewees to share their experiences until they felt they had said what they wanted to say.

The interview transcripts were analysed by the first author using a modification of Colaizzi's (1978) seven stage analysis. Harris et al, (2003) also describe how they modified Colaizzi's method in a study utilising Gadamerian-based research approach. Colaizzi (1978) suggested that his method should be used flexibly by the researcher but "significant modification" is needed when his method is used in a study guided by the work of Gadamer (Fleming et al, 2003, p. 115).

The first author therefore also utilised van Manen's approach to data analysis (van Manen 1990). van Manen's activities of data analysis proposes describing the

phenomenon through the art of writing and re-writing. This activity acknowledges the researcher's role in the research process (Dowling 2007).

Each transcript was read while listening to the audiotapes simultaneously to ensure correct transcription and interpret what emotions and values were being expressed. Each transcript was then read and re-read several times to gain an understanding of the whole. Initial interpretations of the transcripts were recorded and the transcripts were read again. van Manen argues that interpreting the meaning of a text is more accurately “a process of insightful invention, discovery or disclosure- grasping and formulating a thematic understanding that is not a rule-bound process but a free act of “seeing” meaning” (van Manen 1990, 79). Significant statements and phrases pertaining to providing comfort to palliative care patients were then identified and four main themes (Table 1) emerged. Each transcript was then read again with the four main themes in mind and the sub-themes were identified (Table 1). Each transcript was then re-read as a whole and a ‘*précis*’ (summary of each interview) was formulated. Each nurse was then asked to review and validate the summary of their interview transcript.

Despite accusations by Koch (1996) that when using such a framework, the researcher “remains aloof, their panorama of their views and interests are bracketed” (p. 178), Serge and Austin (2001) highlight that many empirical phenomenological researchers who use for instance, Colaizzi's method “recognize that hermeneutic activity (i.e. interpretation)” is an intrinsic part of the research activity (p. 8). Serge and Austin (2001) found that using two approaches to analyse a transcribed interview (an empirical approach such as that proposed by Colaizzi and a hermeneutic

phenomenological approach with no step-by-step method) resulted in a “considerable degree of similarity” (p. 13) and both descriptions were described as being “interpretive” (p.13). Also interesting was their conclusion that the hermeneutic phenomenological description was a “partial one, and other shared themes would have emerged if a lengthier, more complete description had been developed” (Serge and Austin, 2001, p.13). Serge and Austin (2001) conclude that “the broad range of phenomenologically oriented approaches...may not be as different as their surface characteristics and philosophical orientations might lead us to believe” (p.15).

Study findings

From the data, four main themes (with sub-themes) emerged as central to nurses’ lived experience of providing comfort to palliative care patients in an acute care setting (Table 1).

Table 1. Study findings

Main theme	Sub-themes
1. Time needed to provide comfort	a) Environment - provision of facilities. b) Issues regarding place of care. c) Space and Dignity.
2. Emotional cost to the nurse in providing comfort	a) Reciprocity and the nurse-patient therapeutic relationship. b) Ethical comportment. c) Engagement and detachment. d) Nurse advocacy and the role of mediacy, empowerment and enabling on behalf of the patient/family.
3. Holistic approach involved in providing comfort, i.e. physical, emotional, spiritual and psychosocial support	a) Physical needs b) Spiritual needs c) Family
4. Education and expertise and their role in providing comfort	a) Communication skills b) Involvement of palliative care experts

Theme 1: Time needed to provide comfort

All of the participants identified time as an essential component in the provision of comfort. However, the difficulty of having adequate time emerged strongly. Nurses' time in the acute setting is in high demand as the pace is fast. Therefore, the expectation on nurses to free up time to provide comfort to palliative care patients can be frustrating.

Nora: "time is a big thing. One has to have a certain amount of time to be able to provide all this care...All you can do is your best to find enough time to

do, to be able to attend to the basics.....you can't have a palliative care patient not getting the best care that they can get".

Grainne: *"...because you have extra patients on the ward that you're looking after, plus the palliative care patient, and sometimes they can take an awful lot of time, you know they can take more time than any other patient you could have in total".*

Some nurses also expressed the view that they needed to create a suitable environment of rest and relaxation to promote comfort. Lack of privacy for palliative care patients also emerged as a sub-theme, which often added distress on patients, relatives, and other patients. Lack of privacy in this context cost the nurses more time as they invested energy and time in trying to give the impression of privacy by manipulating the environment i.e. moving furniture away to create more space or providing more suitable seating for family members to use, screening off areas around the patient, talking in hushed tones to each other and other patients out of respect for the patient/family involved. All this takes time in a conscious effort on the nurse's behalf to try and provide a more spacious, quiet, private and comfortable area around the patient often in over-crowded wards with unsatisfactory ward facilities.

Theme 2: Emotional labour of providing comfort.

Emotional labour was also identified as an integral part in the provision of comfort to palliative care patients. Participants talked about the role of the nurse-patient relationship and its emotional effects.

Maria: *"When I come back next week, the patients for palliative care maybe still be there, whereas the other patients will all have moved on, feeling better and cured...so it's very hard to have renewed energy, and vitality...".*

Alison: “...*They are very vulnerable when they come into our four walls, and until they build up a rapport with you. I don't think they would open up and discuss their feelings or thoughts with you. if they are worried about a particular thing, they will open up and talk to you*”.

Susan: “...*I used to go and visit a couple of patients on the palliative care ward, and they weren't happy, because they weren't around the nurses that they knew, and loved, and knew for so long. Because patients do get attached to certain nurses, and I know, personally... I know you're not supposed to, but nurses get attached to certain patients. So in that respect it's important*”.

Susan's interview is particularly revealing. She expressed what she viewed as the patient's perception of comfort. This was not solely based in the location of the nursing care but more in the rapport and therapeutic relationship that has been built up and fostered by the nursing staff who delivered this nursing care. Often the nurses (including her) would visit a patient when he/she was moved to another ward to follow up on how the patient was getting on and in some way maintain this therapeutic relationship.

Ethical comportment was also identified as an important unseen element in getting the professional relationship off to a good start. It was described by Nora as “*how you present yourself to the patient*”, and was considered the first step to providing comfort to the patient. Balancing engagement and detachment also emerged strongly.

Imelda: “...*there are days when I feel I don't have the experience or the tools necessary to deal with their emotional needs, because, it's easy to deal with a physical need, it's very easy to give a tablet, its very easy to give an injection, but it's like what's going on in their heads....I do tend to leave it at the door when I walk out, whether that makes me very hard, I don't know. But I have that ability within me, not to take it home. And as I said, my tool within myself that I can actually leave it at the door is very, very helpful to me...* ”.

Three of the nurses interviewed spoke about patient advocacy and the role of empowering and enabling on the patient's behalf. They recalled a time in the 1960's

and 1970's when nurses' input into patient care was not valued and how this had now changed.

Louise: *"...I see a huge difference. Nobody understood, or yeah, there's a better understanding of how... or better appreciation maybe. And people expect to die pain free and with dignity now."*

Imelda: *"...nurses need to be more forthright and say' right, I'm going to need an extra hour today to sit with Joe' to say right, I have to give time to him emotionally, and maybe I have to be his advocate..."*

Theme 3: Holistic approach.

Participants expressed the view that palliative care is synonymous with holistic care.

Siobhan: *"So, yeah, for their comforts, you've got to look at it from a holistic approach – their physical comfort and their mental comfort as well. Because I feel that so much is going on in their mind"*.

Maria: *"Holistic care would be what you're aiming at, and in the pie chart, the family actually in my view, take a large part of it"*.

Siobhan elaborated on what she meant by 'mental comfort'. She viewed this as being free from worries and anxiety. She said this in the context of talking to a dying patient who revealed their concerns about who they are going to leave behind and who will care for their loved ones when they are gone. By facilitating patients to express their concerns and fears, she believed nurses facilitated patients' mental comfort.

Participants also expressed the view that considerable care is required to ensure physical comfort.

Susan. *"A lot of it was physical-was repositioning or washing. A lot of it was pain control as well"*.

Grainne: “.....it’s the small things sometimes that matter, that you reposition their pillows, or give them mouth care, or clean their teeth and comb their hair and they look nice for the day”.

Meeting patients’ emotional needs was also expressed in the provision of patient comfort.

Emer: “other ways of comforting the patient, like just sitting with the patient, and talking to the patient, and addressing any anxieties. Providing comfort in the sense that you actually explain things to the patients”.

Fiona: “ I suppose really with the comfort part of it, I’m focusing more on the emotional well-being of a patient, because I think that if they can have a positive outlook, it really helps them..... I think the emotional well-being of the patient is paramount to them”.

Spiritual needs were also identified as being individual and private. However, patients’ spiritual needs can get overlooked in the array of other care issues that appear more pressing to the nurse.

Nora: “I suppose for a palliative care patient, sometimes you have to... a nurse has to be aware that there possibly could be a spiritual need there, that sometimes that nurses don’t always get into, because spirituality for people sometimes can be very, very private... ”.

The majority of participants identified family involvement/support as important in providing holistic care to palliative care patients in the acute setting, especially when the patient is unable to develop a rapport with the nurse.

Imelda:” Because I didn’t know the patient, and hadn’t built up a rapport with him, I felt....I’m just going through the motions here, to a certain degree. Because I know his family, yes, I provided them with more support than I provided him”.

Maria “ *I can’t really remember any palliative care patient, without remembering their family actually. I didn’t realise that now until I began to think about it, but family...even if the family member is the other side of the world, they still have an impression on me, and I would still know them just as much as the patient actually. But there again, I can name out every member of her family, and where they are in the world, and it’s amazing – the family in a palliative care situation are very, very important, and need a lot of time...* ”.

Theme 4: Educational support needs

Six participants identified the need for on-going education on symptom management, medication usage and the syringe driver. They highlighted this as being important in order to provide their patients with optimum comfort.

Claire: “ *You’ll find that the general setting that some nurses may not be familiar with the pumps which are used to deliver pain medications, and anti-emetics, and further medications* ”.

Moreover, the support that newly qualified staff need when caring for palliative care patients was highlighted.

The valuable role of the palliative care team was also clearly identified as vital to support palliative care patients and nursing staff in the acute setting. However, some nurses also talked about the problems when direct access to the palliative care team was not available.

Claire: “*Such needs are attended best by experts from many disciplines. The big difference between looking after somebody in the acute, general hospital or in the general hospital would be that, you may not have all of the team, when needed*”.

Edel: “*..You haven’t as much back-up support of all the allied disciplines – you have to send for them all*”.

Maria: “*...you need specialised consultants and nurses, and there’s no way you can be an orthopaedic nurse looking after orthopaedic patients one minute, and then palliative care patients, and their medication, the next minute, and what*

works best, and the cocktail of it all, to get the right combination for everything”.

Discussion

Methodological aspects

The findings presented here only apply to the context and the point in time of this study. With phenomenological interpretation there is no clear end-point to the interpretation. A deeper interpretation is always possible and interpretations are always open to re-interpretation. Also, if this study adopted a grounded theory approach, the constant comparison method would have been adopted. However, the theoretical formulations presented when using the constant comparative method may also change in light of new conditions (Chiovitti and Piran, 2003). Moreover, only one group of nurses was interviewed so the findings cannot be applied directly to nurses in similar settings. However, the aim of this study was to illuminate the experience of these nurses in their provision of comfort to palliative care patients so that others might critically reflect on their own practice. No patient views were sought or included. It would be interesting to ascertain their views of their lived experience of receiving comfort and to compare and contrast it with nurses' lived experience of providing comfort. Finally, the first author who conducted all the interviews is a clinical nurse manager with expertise in palliative care from the hospice setting. The nurses interviewed were all aware of this and this may have influenced the information they shared during the interviews. However, this knowledge of each other contributed to the openness experienced in the interviews, where many emotions were expressed by the interviewees, including tears and laughter.

Aspects of the findings

The emotional care provided to palliative care patients in the acute hospital setting emerged strongly in the nurses' narratives. However, when nurses take time to talk to patients, they must then contend with other competing work demands (Mok and Chiu, 2004). Also evident in the nurses' narratives is the perception embedded historically in nursing practice that 'talking to patients' or 'being with patients' is not considered 'real work.' (McQueen, 2001; Chant et al, 2002).

The need to get to know the patient revealed here is also reported elsewhere (Jenny and Logan, 1992; May, 1995; Luker et al, 2000). Moreover, the findings reported here concur with a study on the hospital environment (Williams et al, 2008), where it is identified that key elements and facilities need to be in place for patients and nurses to experience environmental comfort.

The emotional labour of providing comfort to palliative care patients emerges strongly. These findings further echo those reported by Henderson (2001) who notes that personal emotional investment is virtually unrecognised and is certainly unacknowledged, but involves feelings and personal vulnerability. Two important aspects of nurses' practice are evident here. Firstly is the implicit nature of tacit knowledge (Eraut 2000) evident in the provision of comfort and secondly is the value nurses place on their emotional labour. However, the decision of any nurse to emotionally engage with a patient exposes the nurse to potential personal as well as professional costs (Kadner, 1994; Henderson, 2001). The Royal College of Nursing (2000) argues that the most valuable resource a hospital has is its staff and the skills of those staff. They advise that managers and indeed nurses themselves acknowledge

the place and importance of emotion work in nursing and put systems in place so nurses feel supported and valued for this unseen work that they do. This view is supported by Eraut (2007) who highlights the importance of working alongside colleagues who will provide feedback and support.

A holistic approach to the provision of comfort emerged strongly in this study. This is evident in the interview transcripts, where emotional, spiritual, psychosocial and family needs, along with physical needs were identified. Palliative Care, within the sphere of its speciality, has long been recognised as being holistic in nature (WHO, 1990) and in its philosophy (Randell and Downie, 2006). Moreover, dying patients have a basic need to be valued (Mok and Chiu, 2004) and participants of this study demonstrated maintenance of this value by the care and comfort given recounted.

The spiritual needs of palliative care patients also emerged in the nurses' narratives. Spirituality is central to holistic health-care and interacts with physical, psychological and social components (Elsdon, 1995). However, factors that influence spiritual care are, lack of time, and lack of privacy (Ross, 1994). Similar issues were found to negatively impact on comfort care as part of the findings in the narratives for this study.

The importance of family involvement in the provision of patient comfort also emerges. The family remain the most important social context to consider when determining interventions to positively influence patient outcome (Leske, 2002). When the family is comfortable, energy is conserved, and anxiety is reduced, which impact positively on patient comfort (Leske, 2002). Moreover, Spichiger (2008) illustrates the integrated role of family and patient in the end of life experiences in a

hospital setting. She notes the valuable role the nurse has in displaying an approachable and friendly demeanour in order to promote communication which then contributes to the family feeling involved and supported. This aspect of care was verbalized in the narratives from participants for this study.

The final theme identified the importance of education and access to palliative care expertise. The positive impact that hospital-based interdisciplinary palliative care teams have on patient/family care was also expressed. This view concurs with that of Chong et al (2004). However, participants identified their main focus of attention and association with palliative care on symptom management and the use of technical equipment (syringe driver) in the relief of these symptoms. According to Becker (2007), this narrow view of the role of palliative care (scientific and technical elements) while valued and important, flourishes to the detriment of other intrinsic elements, such as truth telling, spiritual care, ethical issues and understanding grief and loss as a lived experience for patients and families. Moreover, participants failed to recognise the expert role they perform regarding the above elements in symptom management and identified their lack of scientific knowledge regarding symptom management as being a negative factor for them.

Conclusion

Previous investigation into and on comfort focused on the concept of comfort, (Hamilton, 1989; Kolcaba, 1992, 1994; Morse et al, 1994) or identifying the components of comfort (Morse, 1983), or describing the process of comforting, (Cameron, 1993; Morse, 1992). This study illuminates nurses' lived experience of providing comfort to palliative care patients in an acute setting. The need for time to

promote comfort was a major theme that emerged from the participants' narratives. Nurse Managers should be cognisant to this factor when allocating patient care per shift. The acuity and dependency levels should reflect the small luxury of allowing the building of nurse-patient rapport which facilitates the provision of holistic care. Reducing the post-operative allocation to the nurse who has a palliative care patient, would also assist in providing uninterrupted time necessary to provide comfort.

The difficulties in applying the philosophy of palliative care in an acute hospital has been discussed elsewhere (Georges et al 2002). Working in the acute setting as opposed to a specialised palliative care unit can lead to role confusion, because when caring for the acute patient, the philosophy is guided by technical, scientific and curative treatment. Caring for the palliative care patient in the acute setting requires the nurse to suddenly switch to the all embracing holistic philosophy of palliative care. A support system should therefore be in place to allow nurses to express emotional fatigue within a supportive framework in the workplace. Moreover, the knowledge and expertise of specialised palliative care teams could be extended to the non-specialist staff in the hospital by the specialist team providing in-house education sessions. This would have a two-fold benefit; firstly, it would meet holistic education needs, as identified by participants of this research. Secondly, it would help establish and maintain professional rapport and respect, which is vital for any effective teamwork.

In conclusion, the study findings presented here will facilitate a greater understanding of the particular challenges and difficulties experienced daily by non-specialised general nurses face while providing comfort to palliative care patient in the acute setting. It also highlights the importance of support from nurse managers, nurse

educators and palliative care teams for nurses providing comfort to palliative care patients in acute care settings.

Key phrases

- Providing comfort to palliative care patients in an acute setting can be difficult without adequate time.
- Nurses invest emotional labour when providing comfort to palliative care patients.
- Providing comfort to palliative care patients requires a holistic approach to care
- Nurses providing comfort to palliative care patients in an acute setting need educational support and access to those with palliative care expertise

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