ORIGINAL RESEARCH

The views of nurses working at palliative care centers about palliative care and the influence of education on their knowledge level

Metin Dincer[1], Nazan Torun[2]

[1] Yıldırım Beyazıt University, Health Institutions Management, Faculty of Health Sciences, Ulus State Hospital, Ankara, Turkey
[2] Yıldırım Beyazıt University, Health Institutions Management, Faculty of Health Sciences, Ankara, Turkey

Abstract

This study is conducted as a qualitative research in order to determine the effect of education on knowledge level and attitudes of nurses about palliative care (PC). 42 nurses participated in this work voluntarily. Open-ended questions are used in order to measure the knowledge level and attitudes of the nurses about the palliative care. 10 open-ended questions are asked to participants before training (both theoretical and practical training), and 12 open-ended questions are asked after training. The obtained data are subjected to thematic analysis. 6 main themes are found out as a result of the study: "The Meaning of Palliative", "Improving the Quality of Life", "A Great Part of Care: Patient's Family/Relatives", "Incompletenesses", "Communication and Colloboration" and "Difficulties". Before and after the training, differences are seen in the knowledge level and attitudes of the participants in palliative care, in the sub-categories of the meaning of the palliative care and in improving the quality of life and in the category of ethical dilemmas. As a result, it is observed that the knowledege level of the nurses working in the palliative care centers (PCCs) has improved and developed after the training program. Palliative care has an important place in maintaining the integration of palliative care to health care services.

Keywords: Palliative care, knowledge, attitude, perception, education, nurse

Introduction

In developed countries, as the life expectancy increases, chronic diseases and cancer cases are also ever-increasing [1,2]. Palliative care (PC) has become an ever-increasing need due to its support for improving the quality of life of patients with these diseases/elderly patients in the last periods of their life. [3]. In 2014, the World Health Organization (WHO) made its first global decision on PC for the development of PC, which is an essential component of the health care system [4]. In cases where death is inevitable, PC aims to make patients' live their last days in a qualified way, with the philosophy of 'good death' for people and getting PC is considered as one of the basic human rights [5]. PC is a humanitarian approach to patients who have pain and physical, mental and ethical problems as well as [6].

Whereas PC services are provided by experts at home in some countries, it is also provided at hospitals and also by the private sector in the form of day care homes in other countries [3,7]. In the UK, Europe, Australia, New Zealand and North America, PC service is provided in the form of an experted PC model [3,8].

In the rural areas of Canada, the PC service is provided at home to the patients who have a fatal disease and to maintain them to live their last days at good quality both economically and strategically [5]. While PC centers (PCCs) are considered as a medical professional field in developed countries, PCCs have also started to be established in developing countries [9].

Compared with the other countries, unfortunately, the PC service has begun to be provided lately in Turkey. In order to identify, evaluate and cure the pain and other symptoms related with the diseases and in order to improve the quality of life of the individual by taking the patient and his family as a whole in psychosocial and spiritual terms, the PCCs began to be generalized in 2015, in accordance with the Directive of Ministry of Health Guidelines for Implementation Procedures and Principles About Palliative Care Services [10].

In Turkey, the PC service is envisaged to be provided by PCCs at hospitals, by the medical staff not-experted in PC area, by family doctors and by the health care staff at the home of the patient [10].

PC has become a vital need for patients with other life-threatening diseases such as alzheimer and other types of dementia, cancer, cardiac vascular diseases (except sudden deaths), liver cirrhossis, chronic obstructive lung diseases, diabetes, HIV (human immune deficiency syndrome) / AIDS (Acquired Immune Deficiency Syndrome), renal insufficiency, multiple sclerosis and parkinson's

Coresponding Author: Metin Dincer, Yıldırım Beyazıt University, Health Institutions Management, Faculty of Health Sciences Ulus State Hospital, Ankara, Turkey.
E-mail: drmetindincer@yahoo.com

disease [11]. In Turkey, no specific patient group has been indicated as the PC treatment receiving segment, but usually cancer patients, geriatric patients, patients with pressure injuries, nutritional deficiency and patients confined to bed are determined [10].

Since PCs are provided in different contents in almost every country, they also vary with regard to their definitions and perspectives in many countries. Definitional differences usually cause role ambiguity and delayed patient/service guidances among employees, by creating gaps in service provided to patients and families and could also limit the effectiveness of PC programs [12].

Since it is a new implementation in our country, we are of the opinion that there is not enough information about PC among health professionals and this situation may change with education. At the same time, we are also of the opinion that together with the fixing and improving the wrong attitudes and information about education and PC, the quality of health service shall be improved. In terms of developing a policy in order to identify the deficiencies and malfunctions in PC services, this study is of prime importance. Therefore, this study is planned to determine the effect of education and knowledge level and attitudes of nurses working at PCCs, towards PC.

Material and Methods

The study is planned to be carried out with the nurses who have participated in the training program conducted at the Ankara Ulus State Hospital, authorized by the Ministry of Health Public Hospitals Institution of Turkey in order to provide training for the "Palliative Care Nursing Certified Training Program". The study is conducted by educational programs held during February 13-March 3, 2017, March 13-31, 2017 and April 3-21, 2017. 14 nurses participated in each trainig programme. Since it is aimed to reach all the nurses participated in the programme, sample selection method is not used. 42 nurses (100%) voluntarily participated in this survey.

In the study, open-ended questions used as the primary data collection tool in order to determine the knowledge level and attitudes of the nurses about PC, who are working/planned to be employed at PCCs. 10 open-ended questions are asked to participants before training (first implementation), followed by theoretical training (second implementation) and 12 open-ended questions after practical training (third implementation), in written format. The aim of this was to enable the participants to answer questions easily. The first 10 questions asked before and after the trainings were same. 2 additional questions are asked after the trainings. These questions are intended in order to determine whether the participants acquired a new thought and/or a misconception about the PC after the training they had received or not. Besides, by means of data collection, demographic informations of the participants are collected before open-ended questions.

The training program consists of 3 weeks including 1 week theoretical (35 hours) and 2 weeks (80 hours) practice. The lesson contents of theoretical and practical training consist of the subjects specified in the standards of the "Certified Training Program of Palliative Care Nursing" approved by the Ministry of Health.

In order to conduct the study, permission is obtained from the Ankara Second District Public Hospitals Association. The permission of the ethics committee of the research is received from the Ankara Numune Training and Research Hospital (10.01.2017 E16-1158).

The results of the research can not be generalized to nurses and other health personnel working in all PCCs.

Statistical Analysis

Age is determined by visually and by Shapiro Wilk test, in which the distribution of working time was not normal. These continuous variables are expressed in median (min-max). The categorical variables such as the type of hospital, gender and educational status are identified by numbers and percentage.

During the analysis of the data, the content analysis method, which is one of the basic methods used in the analysis of qualitative researches, is used. The answers given to the questions are transferred into the virtual platform. The data are evaluated after reading many times and codes were generated which could be picked up by each word. After these generated codes, the thematic coding stage is started, the codes are classified and appropriate themes are extracted. Then, the findings are interpreted and put into the report form.

Results

The median age of the participants is 33 years (min-max: 21-50), where 83% of those are women (n = 35). 62% (n = 26) of the participants had bachelor's degree, 62% (n=26) of them are working at state hospitals and the remaining are working at education and research hospitals. The median of the total working duration of the participants is 12 years (min-max: 1-30), while median of the working duration at the PCC is 13 months (min-max: 0-48) (Table 1).

The data obtained from the questions are evaluated under 6 themes such as "The Meaning of Palliative", "Improving the Quality of Life", "A Great Part of Care: Patient Family/Relatives", "Incompletenesses", "Communication and Colloboration" and "Difficulties", which are submitted as follows (Table-2).

Table 1. Participant characteristics

	n (%)
Age*	33 (21-50)
Gender	
Female	35 (%83)
Male	7 (%17)
Level of Education	
High School	3 (%7)
Further Education	10 (%24)
University	26 (%62)
Master Degree	3 (%7)
Institution of Work	
State hospital	26 (%62)
Training and research hospital	16 (%38)
Total duration of work (years)*	12 (1-30)
Duration of work in the PCC (months)*	13 (0-48 ay)

Table 2. Themes for Palliative Care

Themes	Statements Before Training	Statements After Theoretical Training	Statements After Practical Training
The Meaning of Palliative Care	" Besides symptomatic treatment... care period where works are conducted (No:1)", "…scheduled care period for expressing himself and being comfortable (No:28)", "....care provided to reach for a painless and honourable death (No:37)."	"Life-threatening…problems by patient and his family… a health service that provides a qualified life (No:1)", "...is a health service for reducing the symptoms of…(No:2)", "...is a health service that provides for the family to pass the mourning period in the most appropriate way (No:23)."	"...providing support for the patient relatives during mourning process (No:29)", "...of the patient and his family…improving the quality of life and supporting the mourning prrocess (No:31)", "…patient and patient's relatives…is a supporting process during the mourning process ...(No:32)
Improving the Quality of Life	"Reducing the patient's pain and offering to be more comfortable… (No:26), "…a comfortable and a good care…(N0:31)", "…reducing the pain of the patient…having a more comfortable period....(No:15)"	"Qualified life, painless life…(No:16)", "providing a qualifed life, patient and patient's family… (No:19)", "…ensuring the remaining days to be lived in a qualified way. .(No:23)"	"…giving spiritual support, psychological support (No:36)", "…ironing out the maintenance needs, social support (No:7)", "Supporting and guiding the patient and patient's family (No:32)",
A Great Part of Care: Patient's Family/ Relatives	"Plays an important role in continuing the care at home…(No:2)", The relatives of the patient…is of great importance (No:11)", "…the patient's relative who takes care with love and attention…ensures the patient to be more comfortable...(No:29)".	"…that serves as abridge between health care staff…the most important component within the context of palliative care...(No:4)" "patient's relative plays role at first degree… (No:8)", "…is very important at patient care. It supports the patient… (No:36)"	"…has a very important role…(No:1)", "The role of patient's relatives at pallitive care is very important… (No:7)", "patient's relatives are important in the sense of meeting the physical needs and psychological support …(No:21)"
Incompletenesses	"..Inadequacy of application area, inadequacy of staff working at the services, lack of a seperate unit as a service, independent from the other services....(No:3)", "Considering palliative care as intensive care and trying to cure the disease ...(No:6)", "Physical conditions are not same at everywhere…(No:26)"	"…Even other health care staff not having knowledge about palliative care …(No:4), "palliative care needs to be seperated from intensive care at minds...(No:8)", "…not having enough information about which type of patients should stay in hospital (No:28)",	"...Incompleted/inaccurate legal regulations (No:23)", "...being not clear the patient group (No:34)", "Not knowing the purpose of palliative care and misapplication ….(No:30)"
Communication and Colloboration	"…should be conducted in collaboration...(No:9)", "…must be in collaboration with home care … (No:20)", "...since patient's relatives are not in cooperation with… .(No:25)"	"...is an approach which is communicated with the family (No:20)", "…the one who cooperates with the patient's relatives while implementing it….(No:26)", "...must be in cooperation with at home care (No:36)",	"…providing spiritual support, continuity in communication (No:19)", "...is one of the biggest communication ways between multidisciplinary staff and patient and patient's family. (no:23)", "The problem with the patient's relatives is not making contact with them.…(No:35)",
Difficulties	"...the patient's relatives not accepting the situation …(No:3)", "...generally CPR is not demanded to be conducted (No:5)" "...te reluctance of the patient's relatives…not being in collaboration with the health care staff …(No:12)"	"...not accepting the death process… (No:5)", "... since the patient rooms are double, it is difficult to protect privacy…(No:9)", "revival command, giving bad news, not receiving consent (No:19)"	"…reluctance to looking and learning. (No:9)", "Should the treament come to an end or continue? ...(No:28)", "instability about giving information to the patient about his illness (No:42)"

The Meaning of Palliative Care

1. Participants in practice identified the meaning of PC as termial period patient, non-curable disease, patient family/relatives, and relieving/reducing pain and suffer, improving/increasing the quality of life, eradicating/decreasing the symptoms, psychological and spiritual rehabilitation and the meaning of PC as the maintenance period.

2. After the practice, the participants identified the meaning of PC as life-threatening disease, patient and patient's family/ relatives, relieving/reducing pain and suffer, improving/increasing the quality of life, psychosocial, physical and mental needs, eradicating/decreasing the symptoms and the mourning period and they identifed the meaning of PC as holistic approach and health care service.

3. After the training the participants identified the meaning of PC as life threatening and non-curable disease, patient and patient's family/relatives, psychosocial, physical and mental needs, relieving/reducing pain and suffer, improving/increasing the quality of life, eradicating/decreasing the symptoms and the mourning period and they identifed the meaning of PC as holistic approach and assisting the process.

Improving The Quality of Life

1. Participants in practice identified the goals of PC and the needs of patients as eradicating/decreasing the symptoms, relieving/ reducing pain and suffer, providing nutrition, personal care, psychological support, improving/increasing the quality of life and increasing the quality of life by enduring a comfortable life.

2. Participants in practice identified the goals of PC and the needs of patients as eradicating/decreasing the symptoms, relieving/reducing pain and suffer, preparing for the death process, dying peacefully, psychological support and improving/increasing the quality of life.

3. Participants in practice identified the goals of PC and the needs of patients as eradicating/decreasing the symptoms, relieving/reducing pain and suffer, preparing for the death process, providing an honourable/peaceful death, psychological support, improving/increasing the quality of life, comfortable life, teaching to family the maintenance and increasing the quality of life by physical and psychological support.

A Great Part of Care: Patient's Family/Relatives
Participants identified the importance of the patient's family/relatives in all 3 implementations as has a great role during care, has the first degree role during care, the continuity of care at home, providing psychological/spiritual support to the patient, information source about the patient, being a bridge between the patient and health care team and supporting the health care team.

Incompletenesses
In all 3 implementations, the participants identified the incompletenesses of PC as lack of adequate legislation, being a new/unrecognized unit, uncertainty of the patient group which is being examined, inadequacy of personnel and multidisciplinary team, lack of personnel information, lack of an independent unit, misusing, inability to integrate at home, lack of standards and deficiencies at materials and physical conditions. Moreover, it is observed that 5 people in the first implementation had no information about the inadequacies in PC and that they got information after training.

Communication and Collaboration
In all 3 implementations, the participants stated that the communication and the collaboration between the healthcare staff and patient's family/relatives will provide convenience and if it is no used properly, it will cause difficulties and that PC is an approach, which is realized by the communication and collaboration of PC.

Difficulties
In all 3 implementations, the participants stated that PC is the ethical dilemmas, the problems experienced with the patient's family/relatives and the difficulties experienced at the maintenance during the last period of life.

In all 3 implementations, PC is identified as the reluctance of the patient's family/relatives to participating in the maintenance, the lack of cooperation, not accepting the disease and death, aggressive behavior during the mourning period and the process during which emotional influences of the nurse is experienced.

However, in the category of ethical dilemmas, since the participants didn't have much information on this subject before the training, different categories are found out after the trainings. It was observed that while the majority of the participants didn't reply the ethical problems experienced before the training, that the great majority of the other participants didn't give meaningful answers. Similarly, it was observed that 5 participants did not have

any information about life-end care before the training, and the other participants who replied were not fully informed. However, this situation changed after the trainings.

In the first implementaton, ethical dilemmas are identified with only whether the CPR application is made or not, and giving/not giving damage to the patient by making unnecessary transactions. In the second and third implementations, it is stated that there are ethical problems at PC such as to whether CPR application is performed, giving/not giving damage to the patient by unnecessary operations, hiding the information about the patient's disease, consent forms, starting/terminating the treatment and the protection of privacy. To hide patient information about the disease, to proclamation forms, to terminate / start treatment and to protect privacy.

In the study, participants are asked where and why the PC should be provided. In the first practice, the majority of the participants (n = 27) thought that the patient had to receive medical treatment and that the PC should be provided at the hospital, since the multidisciplinary team was only existing at the hospital. However, it was seen that this thought has changed after the trainings. The participants stated that it would be more appropriate for the PC to be delivered in the home environment because the home environment would be more comfortable for the patient and the patient's family/relatives, the treatment is completed due to the patient being a terminal patient and causing a lower cost to the state. The number of 27 participants, who stated that PC should be provided at hospital, decreased after the trainings to 17 participants at second training and to 13 after the third training. However, although there was little (n = 4) opinion about continuing home care after the treatment for symptoms in the hospital before the training and after the education for the patient's family/relatives, it is observed that this opinion increased after the trainings (n = 15).

After the theoretical and practical trainings, participants are asked as to whether they had subjects, which they knew wrong about PC and a new thought, which they realized about PC. It was observed that 6 of the participants didn't reply to a new idea and 13 of them didn't give any answer to the subject which they misunderstood. The participants who replied stated that they understand the philosophy and the purpose of PC in general, their legal rights, which patient groups shall be applied to PC and they understand better that communication and spiritual support are important. Besides, it is also realized that education and mourning process are within the PC, and that the PC consists of not only the patient but also the patient's family/relatives. It is also stated by the participants that the PC should be spread all around the country, the doctors should also be educated on this subject, providing at-home care and integration is needed and multidisciplinary team work should exist.

Participants declared that they performed misapplication at wound treatment in PC, treatment should be terminated and that CPR practice could not be conducted legally, which patient groups had to be applied, that they were not fulfilling their duty at mourning process, that only symptomatic treatment should be performed at the PC and that they noticed that this was a different approach from intensive care.

Discussion

As a result of our study, the perceptions of nurses about PC are explained in 6 themes. Although there were themes at the same names before training and after the theoretical and practical training, there were differences in the categories of ethical dilemmas and in the subcategories of the themes of increasing the meaning of PC and quality of life of PC.

The themes that are revealed in the study are indicating almost the same theme group as other similar conducted works. In the studies aiming to determine the perception of nurses to the PC, the themes of the definition, meaning, communication, delivering service, conditions related with the implementation, family education/importance, collaboration, labour force, education and needs of the PC are found [9,12-14].

In all 3 implementations, it is observed that PC has the meaning that even though there are unchanging points of views such as eradicating/decreasing the symptoms, relieving/reducing pain and suffer and improving/increasing the quality of life, there are also changing point of views.

While in the first implementation PC patient and patient's family/relatives and their needs are not considered, these are considered as a whole in the second and third implementations. According to the participants, while the PC was not covering the mourning process in the first implementation, the second and third implementations were covering the mourning prıcess in practice. In the first implementation, while the terminal period patients are defined as the PC patient group, in the second and third implementations they are identified as life-threatening and non-curable diseases.

Besides, PC in the first implementation is perceived as a care process by giving education to the relatives of the patients. However, while the PC is considered as a health care service in the second implementation, it is considered as a support process in the third implementation.

Comprehensive education and training at PC is important for the success of interventions performed to the patients [15]. However, in many researches conducted, it has been seen that health professionals do not have enough knowledge about PC and education is important for the establishment of PC concept and it is also observed that nurses who completed the "Basic Palliative Care European Certification Training Program" have better knowledge compared with the nurses who did not complete the program [16].

It has been reported in a study that, training programme applied to the nurses and health-care providers are important for teaching the concept of PC to them [17]. Besides, in another conducted study, it was emphasized that the training of the staff about PC was needed in order to improve the quality of maintenance [18].

In a study conducted in Turkey, it has been reported that the majority of hospital managers and clinical managers indicate that there are obstacles about the integration of PC to health system, originated from the interest and knowledge about the PC and training of the staff is needed to provide the integration of PC [19].

There are gaps in the knowledge of PC personnel working in the field of PC and their capacities are needed to be improved by

some applications [9]. Therefore, it is thought that in our country education has an important place in the integration of the new practice of PC into the health system.

The purpose of the PC and the needs of the patients were indicated by the participants in all 3 groups as reducing pain, relieving symptoms, increasing/providing psychological support and quality of life. However, it is observed that in some sub-categories there are differences among the application groups.

These differences are the provision of personal care and nutrition of the patient in the first implementation, the quality of life in the end of life period of the patient in the second implementation, and the support to the patient and the patient's family/relatives in the third implementation. Russ et al. [20] described PC as improving quality of life and end of life care. In a study conducted among health workers, it is seen that end of life care is used in the same meaning with PC [21].

As a result of our work, it is observed that there is a lack of information about PC among health professionals. Since it has been a newly opened unit and due to some deficiencies in legislation, this lack of information cannot be separated from other units, especially from the intensive care unit. It is stated by the participants that in some PCCs, patients in the terminal stage are treated as in intensive care and there are uncertainties at treated patient groups. As a result of our study, it is noted that before the trainings, the patient group in PC was generally described as the patients who have cancer, confined to bed, chronic and neurological disease, who are aged, who have nutritional deficiency and wounds related with being confined to bed. After the trainings, it is mentioned that these patients could also diseases such as alzheimer, dementia, parkinson's disease and AIDS.

Since, it is indicated that the patient group who get service from PC are mostly, the cancer patients and then dementia and alzheimer patients, this study shares similarity with the study of Ross et al [20].

It is determined from the statements that since it is a newly established/being established unit, in some places where the staff is not enough, only the nurses and doctors are present and other health care staff are not existing. After the trainings, the participants stated that there should be health care staff such as "Physician, Nurse, Psychologist, Physical Therapy Rehabilitation Expert, Social Service Expert and Dietitian" in the multidisciplinary team as well as health care staff such as "Spiritual Support Expert, Care Personnel, Speech and Language Therapist and Oncologist." In addition to this, as a result of the study, it is seen that multidisciplinary teamwork comes to the forefront in PC compared with the other units. This result is in the same direction with the opinions of improving the role and qualifications of nurses for the integration of PC standards and the employment of special teams in PC maintenance [12].

After the trainings, participants stated that the whole PC is not incorporating the same standard in terms of physical and material aspects. In a particularly conducted study, the participants stated that there is no single room at each PCCs for patient privacy and for the comfort of the patients's family/relatives at the PC.

Having maintained the same standards for the working staff, the hospitalized patient population and the procedures, which have to

be carried out in all centers, shall be realized by the legislative arrangements, which shall be legislated by the policy makers. By this way, PC can be perceived same at everywhere and it shall cause to eliminating application differences and delivering more effective services.

In all 3 implementations, the importance of patient's family/relative is expressed in the same way at the PC. Being an integral part of the PC of the patient's family/relatives is understood by its support in aspects of spiritual and psychological and that the support to health care staff during maintenance and maintaining communication between the patient and the health care staff.

Along with having a very important role for the patient's family/relatives about the PC, their inadequate knowledge about the PC and being reluctant to patient care, cause difficulties for health care staff.

PC differs from the other health services. The main purpose here is not to make the necessary medical treatment for the patient's health. The main purpose is reducing the physical, psychosocial and mental problems caused by life-threatening diseases by taking the patient and patient's family/relatives as a whole and improving the quality of life of the patient and patient's family/relatives [22]. Besides, the PC includes a mourning period continuing after death. In this process, psychological support to the patient's family/relatives is very important. For this, it is necessary for nurses and doctors to know efficient communication methods and to be in collaboration with psychologist and spiritual care specialist when necessary. In a conducted study, it has been reported that training has increased the quality of care by affecting the knowledge of the nurses and doctors working on the PC positively [23].

In the first implementation, it is observed that the participants didn't have so much information about ethical and end of life care in PC. It is also observed that a great majority of the problems experienced with ethics are caused by legal deficiencies (as to whether CPR application is implemented, giving/not giving damage to the patient by doing unnecessary operations, termination/initiation of the treatment, protecting the privacy etc.). It is thought that, by means of legislative arrangements, the ethical problems that are experienced shall come up with solution.

Due to a study performed by Chih et al. [24], some of the events occurred by the dilemma among health care staff about PC are: hiding the facts from the patient by some families, not giving information about the progress of the disease, overuse of medication and the decision for informing the patient about the bad news.

In another study, the perception of nurses' PC in terms of ethical perspective is dimensioned as paying attention to patient's values, empathizing, respect for the patient, correct speech and correct action, full and multidimensional patient acceptance, supportive behavior and responsibility [6]. Within years, it is determined that ethical dilemmas may change and that resource shortage may increase ethical dilemmas [24].

End of life care is a very difficult situation in terms of psychological and spiritual ways for both the health care staff and the patient's family/relatives. In order for nurses to inculcate both themselves and patient's family/relatives, it is necessary for them having adequate education on this subject.

Researchers have indicated that communication is the most necessary education subject in terms of end of life care and ethics, in the forms of end of life communication techniques, breaking the bad news to the patient, talking to the family, discussing prognosis and discussion of treatment options [20].

A similar result has also been found in a study conducted by Selman et al. [25]. All participants stated that better or more education was needed at the end of life care. They stated the reasons for the need are the obsolescence of the skills and losing their actuality, the inadequacy at the care of the deceased patient, lack of confidence and the complexity of end of life care. In another study, it is also expressed that regional PC programs caused physicians to significant improvements and difficulties, which they encounter about the PC [26].

It has been seen that the opinion about where PC should be given has changed after the trainings. Since PC patient is a terminal period patient, he is only in need of treatment and care for the symptoms in order to live the last periods of his life comfortably. Therefore, patients do not need to stay for a long time in hospitals. Staying over unnecessarily in the hospital causes both hospital infections and increases at hospital costs. Besides, this situation may lead to the isolation of the patient's family/relatives from their social life and even labour loss due to staying in hospital constantly. However, the patient's families/relatives and even the doctors, hesitate about this. The patient is afraid of dying right away, the patient's family/relatives are afraid of losing their patient or being reluctant to take care of him, and the doctors are afraid that if the patient goes home, he will die and the patient's family/relatives will make a complain about it. Therefore, PC patients may stay in the hospital for a long time unnecessarily. In a conducted study, for terminal patients, while the 35% of patients, 30% of patient relatives and 44% of physicians prefer to die at home, 48% of patients, 38% of patient relatives and 7% of physicians prefer to be treated in hospitals, whatever the chance to being recovered is [27].

Conclusion

In this study, it is observed that the knowledge level of the nurses working at PCC about PC has improved and developed after the applied PC certificate-training program. As a result, by means of standardized training programs on PC, it is considered that health care staff will have enough knowledge and experience about PC.

We are of the opinion that there is a need for legal regulations for PC, which is a new practice in our country, in order to be correctly perceived by all health care staff, administrators, PC patients and their families and in order to be provided in a standard format throughout Turkey.

References

1. The top 10 causes of death. http://www.who.int/mediacentre/factsheets/fs310/en/ access date 28.04.2017

2. Life expectancy at birth. http://hdr.undp.org/en/69206 access date 28.04.2017

3. Sandsdalen T, Grondahl VA, Hov R, Hoye S, Rystedt I, Wilde-Larsson B.

Patients' perceptions of palliative care quality in hospice inpatient care, hospice day care, palliative units in nursing homes, and home care: a cross-sectional study. BMC Palliat Care. 2016;15(1):79.

4. http://www.who.int/cancer/palliative/en/ access date 28.04.2017

5. Kaasalainen S, Brazil K, Williams A. Nurses' experiences providing palliative care to individuals living in rural communities: aspects of the physical residential setting. Rural Remote Health. 2014;14(2):2728.

6. Hamooleh MM, Borimnejad L, Seyedfatemi N, Tahmasebi M. Perception of Iranian nurses regarding ethics-based palliative care in cancer patients. J Med Ethics Hist Med. 2013;6:12.

7. Sandsdalen T, Rystedt I, Grondahl VA, Hov R, Hoye S, Wilde-Larsson B. Patients' perceptions of palliative care: adaptation of the Quality from the Patient's Perspective instrument for use in palliative care, and description of patients' perceptions of care received. BMC Palliat Care. 2015;14:54.

8. Ewing G, Farquhar M, Booth S. Delivering palliative care in an acute hospital setting: views of referrers and specialist providers. J Pain Symptom Manage. 2009;38(3):327-40.

9. Fadare JO, Obimakinde AM, Afolayan JM, Popoola SO, Aduloju T, Adegun PT. Healthcare workers knowledge and attitude toward palliative care in an emerging tertiary centre in South-west Nigeria. Indian J Palliat Care. 2014;20(1):1-5.

10. SB. Sağlık Bakanlığı Palyatif Bakım Hizmetlerinin Uygulama Usul Ve Esasları Hakkında Yönerge. 2015.

11. Connor SR, Bermedo MCS. Global atlas of palliative care at the end of life. 2014.

12. Pavlish C, Ceronsky L. Oncology nurses' perceptions of nursing roles and professional attributes in palliative care. Clin J Oncol Nurs. 2009;13(4):404-12.

13. Benzein E, Saveman BI. Nurses' perception of hope in patients with cancer: a palliative care perspective. Cancer Nurs. 1998;21(1):10-6.

14. McIlfatrick S, Curran CI. District nurses' perceptions of palliative care services: part 2. Int J Palliat Nurs. 2000;6(1):32-8.

15. Sleeman KE, Koffman J, Bristowe K. 'It doesn't do the care for you': a qualitative study of health care professionals' perceptions of the benefits and harms of integrated care pathways for end of life care. BMJ open. 2015;5(9):e008242.

16. Wilson O, Avalos G, Dowling M. Knowledge of palliative care and attitudes towards nursing the dying patient. Br J Nurs (Mark Allen Publishing). 2016;25(11):600-5.

17. Potter G, Pesut B, Hooper BP, Erbacker L. Team-based education in a palliative approach for rural nurses and unlicensed care providers. J Contin Educ Nurs. 2015;46(6):279-88.

18. Frey R, Boyd M, Foster S, Robinson J, Gott M. Necessary but not yet sufficient: a survey of aged residential care staff perceptions of palliative care communication, education and delivery. BMJ Support Palliat Care. 2016;6(4):465-73.

19. Kafadar D, Ince N, Akcakaya A, Gumus M. Evaluation of Managerial Needs for Palliative Care Centers: Perspectives of Medical Directors. Asian Pac J Cancer Prev. 2015;16(11):4653-8.

20. Russ A, Mountain D, Rogers IR. Staff perceptions of palliative care in a public Australian, metropolitan emergency department. Emerg Med Australas. 2015;27(4):287-94.

21. Shearer FM, Rogers IR, Monterosso L, Ross-Adjie G, Rogers JR. Understanding emergency department staff needs and perceptions in the provision of palliative care. Emerg Med Australas. 2014;26(3):249-55.

22. Definition of Palliative Care. http://www.who.int/cancer/palliative/definition/en/ access date 25.04.2017

23. van de Geer J, Veeger N, Groot M. Multidisciplinary training on spiritual care for patients in palliative care trajectories improves the attitudes and competencies of hospital medical staff. Am J Hosp Palliat Care. 2017:1049909117692959.

24. Chih AH, Su P, Hu WY. The Changes of ethical dilemmas in palliative care. A lesson learned from comparison between 1998 and 2013 in Taiwan. Medicine (Baltimore). 2016;95(1):e2323.

25. Selman LE, Brighton LJ, Robinson V. Primary care physicians' educational needs and learning preferences in end of life care: A focus group study in the UK. BMC Palliat Care. 2017;16(1):17.

26. Kizawa Y, Morita T, Miyashita M. Improvements in physicians' knowledge, difficulties, and self-reported practice after a regional palliative care program. J Pain Symptom Manage. 2015;50(2):232-40.

27. Steinhauser KE, Christakis NA, Clipp EC, McNeilly M, McIntyre L, Tulsky JA. Factors considered important at the end of life by patients, family, physicians, and other care providers. Jama. 2000;284(19):2476-82.