Skills needed in palliative nursing care through a spiritual perspective in low and lower middle-income countries

A Scoping Literature Review

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Abstract:

Palliative nursing requires skills are important because there are potential implications for health practice on the global level. Palliative nursing care can be developed and spread around the world. The findings gained from exploring palliative nursing care skills and the spiritual perspective can contribute to all who are involved such as the nurse's professional development and patients. This study will provide greater understanding of important perspectives in palliative nursing care which contribute to high quality patient care out-comes. These will give support to the nurses in their future development of holistic palliative nursing care. With focus on the spiritual perspective in low- and lower middle-income countries, this scoping review aims to review existing literature regarding skills nurses need in palliative nursing. The concepts that will be used and defined are nursing, palliative care, spirituality and religion. In addition, the major religions of the world will be explained, and these include Christianity, Islam, Hinduism, Buddhism and Judaism. Information and scientific articles are read and analyzed. A search was conducted on studies between 2014-2019 in the following databases: CINAHL full text, Academic Search Premier and PubMed. A manual search of books and printed articles was also performed. The studies which described palliative nursing care skills though a spiritual perspective were considered. The type of analysis used was an inductive content analysis to summarize and spread what is known about the topic. Three major themes emerged, and these are communication, compassion and giving hope. Some research has been written, however there could still be potential in the future for more research on palliative nursing care.

Keywords:	Nursing, Palliative care, spirituality, religion
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List of Abbreviations

EoLC	End-of-life care
ICN	International Council of Nurses
GNI	Gross national income
LMIC	Low-and middle-income countries
PNC	Palliative nursing care
QoL	Quality of Life
WHO	World Health Organization
WPCA	Worldwide Palliative Care Alliance

FOREWORD

Ever since I was a little girl, living abroad in different countries, getting active and being involved with church and attending church services has been imperative. I was born in Israel, grew up to have an inquisitive, open mind, I treasured learning about religion and spirituality. I enjoy talking to individuals about their own beliefs because as I listen, I learn how it gives them strength to endure any challenge in everyday life. Developing further as a registered nurse, I realized how strongly I felt about palliative nursing care, hospice care and patient's needs in palliative care.

About my upbringings, I am a practical nurse as well as a registered nurse with over 10 years of experience, where I have specialized in caring for the elderly people, hospice care and palliative nursing care. With a wide cultural background, I have been subjected to a lot of other people's religions and cultures as well. Living in Pakistan for a decade, attending an international school opened my eyes to all other faiths as well besides my own. I hope with these little insights about my own life and where I come from offer some subjective perspectives when reading my thesis.

The idea of my thesis originated from the time in Kenya when there was the ongoing intensive program there. I thought about doing something about elderly people, but as the idea evolved and slowly but surely it came to me that I wanted to write something about palliative nursing care through a spiritual perspective. A literature review was the main idea and I needed the patience and huge help of the librarian at Diaconia University of Applied Sciences Marketta Fredriksson. Without her knowledge and guidance of the databases, search terms and relevant literature, this study would have lacked the quality that it now has. I am also grateful for the guidance and constructive feedback from my thesis supervisors Eija Kattainen and Jaana Tilli.

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1 INTRODUCTION

There is a huge importance that palliative nursing care should be available to everyone globally who have a chronic, life-threatening disease. This report is about reviewing existing literature on skills needed in palliative nursing care from a spiritual perspective in low-and lower middle-income countries. The World Health Organization (WHO) defines palliative nursing care as "an approach that improves the quality of life of patients and their families facing the problems associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual." (Sepúlveda, Marlin, Yoshida & Ullrich 2002 p. 91-96)

The concepts that will be used and defined are palliative nursing care and spirituality. In addition, the major religions around the world which are Christianity, Islam, Hinduism, Buddhism and Judaism will be explained more. Information has been collected through reading scientific articles and have then been analyzed. The scoping literature review provides methodologies which have been used to bring up skills needed palliative nursing care.

The World Health Organization has estimated that over 40 million people will need palliative nursing care, even this number may be an underestimate and will be increased at a rapid rate. There are also other statistics shown that a person may not only have one disease but several because the people in the world are growing older, living longer, therefore a person may have AIDS in addition to a cardiovascular disease or diabetes with high blood pressure and wounds. The chief focus should be the person and their holistic needs including spirituality, not just their diseases. (Connor & Sepúlveda, 2014)

Singing, listening, communication, praying, pain relief, being present and mourning. These are all small parts yet important in palliative nursing care which make up a larger picture. When a person is near his or her death, there are actions which the nurses and family members can take. Death with dignity can be planned and implemented. It is with clear ethics and morality that nurses involved in the care of the dying relieve the patients' pain and suffering. Palliative nursing care plays a major role in this process.

The goal of palliative nursing care is to improve the quality of life for both the family members and the patient with the time they have left together. (Sumser, Leimana & Altilio 2019 p. 122-147)

The aim is important to be stated in this report because there are potential implications for health practice on the global level. Palliative nursing care can be further developed and spread around the world. The findings gained from exploring skills needed in palliative nursing care and the spiritual perspective can contribute to all who are involved such as the nurse's professional development and patients. This study will provide greater understanding of important perspectives in palliative nursing care which contribute to high quality patient care outcomes. These will give support to the nurses in their future development of holistic palliative nursing care.

2 GLOBAL VIEWPOINTS TO PALLIATIVE CARE

The Worldwide Palliative Care Alliance (WPCA) is a known system globally that aims at developing hospice and palliative care around the world. The members are from organizations from regional and national development worldwide. Its members are national and regional hospice and palliative care organizations and affiliate organizations supporting hospice and palliative care. (Connor & Sepúlveda, 2014)

It does not matter what type of disease, which stage that disease is at, the person's living setting or the age of the person. Health care workers especially nurses must think about the different kinds of settings where each one of them lives and works. In low and lower middle-income settings, there will be people suffering with communicable diseases such as HIV/AIDS or multidrug resistant tuberculosis. (Connor & Sepúlveda 2014) There may be children with cerebral palsy caused by a problematic birthing or suffering from infections such as malaria. There is a rise in cases where there are people living with noncommunicable diseases such as cardiovascular disease, cancer or mental health problems. It is a fact that the numbers of these cases are growing especially in low-and lower middle-income settings. (Connor & Sepúlveda 2014)

There has been a major development in the area of palliative nursing care in the past 50 years. Successful integration has happened in Australia and the United Kingdom, where it originally started with hospice care. It was towards the end of the 19th century, when hospice became places that were meant for the care of terminal or end-of-life-care patients in Ireland and England. Later in 1967 Dr Cicely Saunders developed the concept of hospice. (Clark 2000 p. 50-55)

2.1 Palliative nursing care

Palliative is derived from the Latin word of "pallium" which means to cloak. (Connor & Sepúlveda. 2014) There are numerous definitions of palliative care, but this work uses the definition in the Oxford Textbook of Palliative Nursing, where the definition of palliative care is: "Palliative care and the medical subspecialty of palliative medicine, is specialized medical care for people living with serious illness. It focuses on providing relief from the symptoms and stress of a serious illness." (Kirkpatricka, Cantrell & Smeltzer 2019 p. 23-30)

The definition continues to say: "The goal is to improve the life for both the patient and the family. Palliative care is provided by a team of palliative care doctors, nurses, social workers and others who work together with a patient's other doctor to provide an extra layer of support. It is appropriate at any age and at any stage in a serious illness and can be provided along with curative treatment." (Kirkpatricka, Cantrell & Smeltzer 2019 23-30) This ideology summarizes up what palliative nursing means, what its goals are and who can receive it.

"Hospice" is derived from Latin "hospitium" and it means guesthouse. It was a place where sick and fatigued travelers would stay after they had been going on religious pilgrimages. (Connor & Sepúlveda 2014) Toward the end of the 19th century in Ireland and England, hospices became known as places for the care of terminal patients. The first hospice in the United States was in 1974. There was also a hospice called "St Joseph's" in Bayswater that was run by nuns and cared for the dying poor people. (Connor & Sepúlveda 2014)

In south west London, a hospice called “St. Christopher’s Hospice” was founded and led by nurse Cicely Saunders. She was really devoted to her work and wanted to take care of people with terminal illnesses. She wanted to make sure the patients that she had cared for before in the war and had suffered greatly in pain and other symptoms would not be repeated. She was adamant in starting a place where patients did not have to feel and experience physical pain and suffering. (Clark 2000 p. 50-55)

The philosophy and practice of end-of-life care, terminal care and palliative care spread globally. For example, in the United States, the volunteers were the main people who oversaw hospice. Then around the 1980s, a formal hospice care was authorized by Medicare. In the early 1990s, hospice developed into an official medical subspecialty where physicians involved in the care of hospice patients could become board certified in hospice and palliative medicine. (Clark 2000 p. 50-55)

There are countries in the areas of the Middle East as well as in other developing countries where there will be an increase of the incidence of cancer in the next 20 years. (Silberman & Esmat 2011 p. 81) Patients with cancer will need high quality care within the holistic aspect. In low and lower middle-income countries, palliative care is an ignored area in health care since other causes are seen to be more important. (Silberman & Esmat 2011 p. 81)

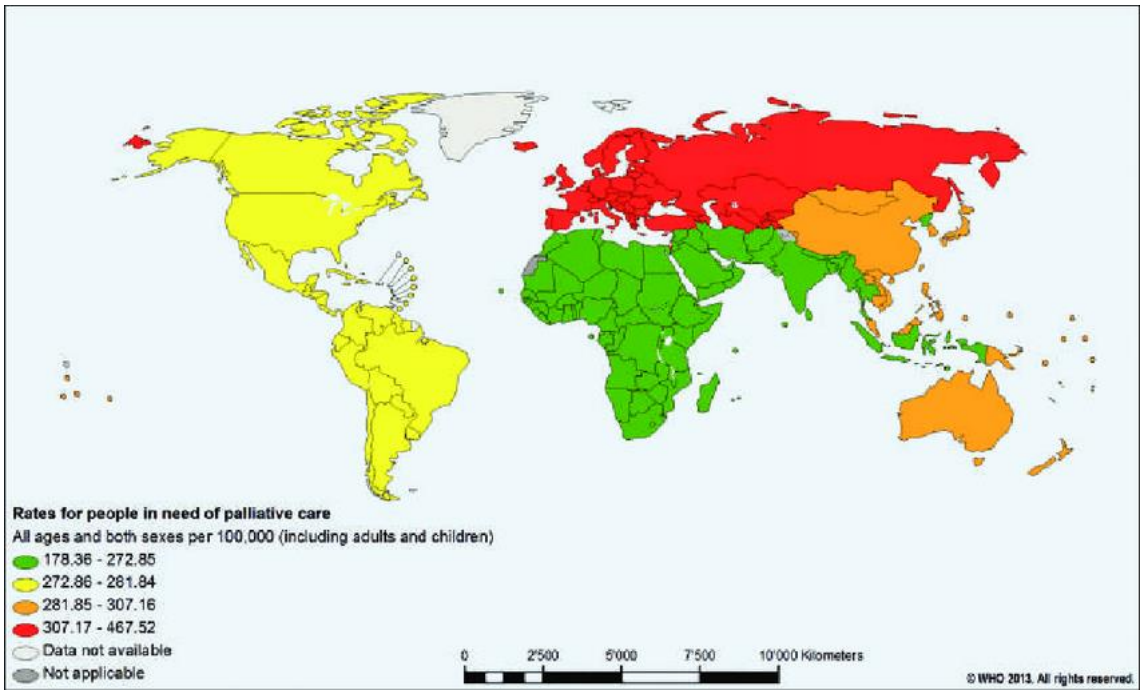

Figure 1 World map showing the global distribution by WHO regions of rates for people in need of palliative care at the end of life

The World Bank has a system in which they classify countries. The economies are divided into four income grouping which include low, lower-middle, upper-middle, and high. The way the income is measured is in U.S dollars by means of gross national income (GNI) per capita, which is converted from local currency using the World Bank Atlas method. The World Bank classifies all World Bank member economies and all other economies with populations of more than 30,000 for operational and analytical purposes. Economies are divided among income groups according to GNI per capita, calculated using the World Bank Atlas method. (Connor & Sepúlveda 2014)

In low income countries there are 31 countries. In lower middle-income countries, there are 51 Countries. In upper middle-income countries, there are 53 Countries. In High income there are 48 countries. In high income areas there are 32 countries. (Connor & Sepúlveda 2014)

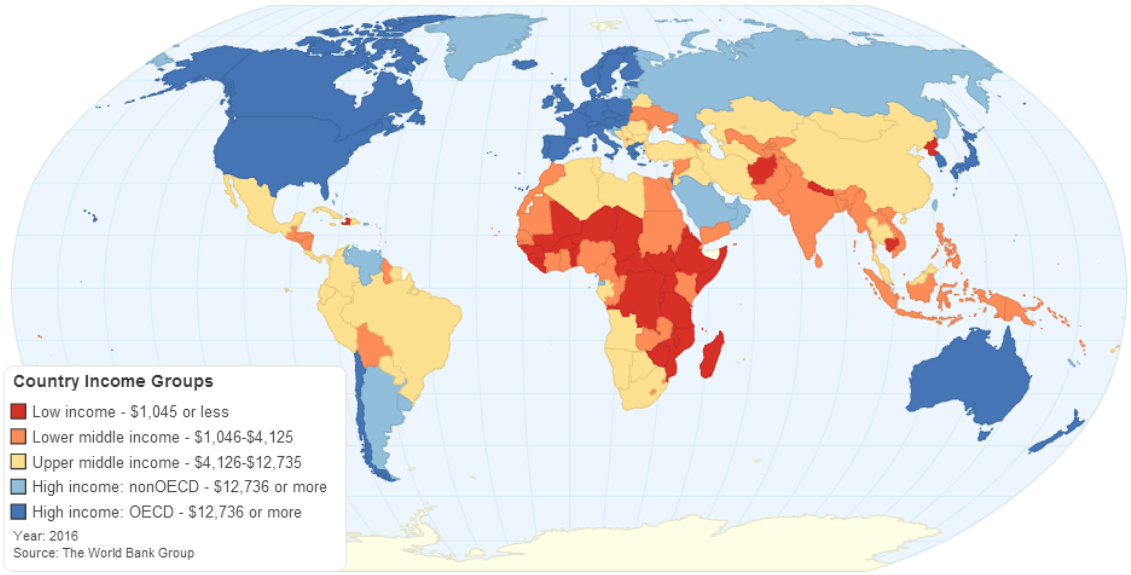

Figure 2 Country Income Groups

Low-income economies are defined as those with a GNI per capita, calculated using the World Bank Atlas method, of $1,045 or less; middle-income economies are those with a GNI per capita of more than $1,045 but less than $12,736; high-income economies are those with a GNI per capita of $12,736 or more. Lower-middle-income and upper-middle-income economies are separated at a GNI per capita of $4,125. (Connor & Sepúlveda 2014)

The estimates of GNI are obtained from economists in World Bank country units. The size of the population is estimated by World Bank demographers from several bases which include the UN's biennial World Population Prospects. In table 1, there are the low-income economies listed and in table 2, there are the lower-middle economies listed. (Connor & Sepúlveda 2014)

LOW-INCOME ECONOMIES $1,025 OR LESS		
Afghanistan	Guinea-Bissau	Sierra Leone
Benin	Haiti	Somalia
Burkina Faso	Korea, Dem. People's Rep.	South Sudan
Burundi	Liberia	Syrian Arab Republic
Central African Republic	Madagascar	Tajikistan
Chad	Malawi	Tanzania
Congo, Dem. Rep	Mali	Togo
Eritrea	Mozambique	Uganda
Ethiopia	Nepal	Yemen, Rep.
Gambia, The	Niger	
Guinea	Rwanda	

Table 1 Low-Income economies

There are two ways that the World Bank has divided low-income countries and lower-middle income countries. They can be seen in table 1 and table 2. The low-income country economies are those countries that have a GNI of $1,025 (U.S dollars) or less. These countries are for example Mali, Somalia, Afghanistan and Liberia. The lower-middle income countries are the countries that have economies of $1,026 to $3,995. These countries are found in Asia and Middle East. They include Vietnam, Myanmar, Indonesia, Egypt, Sudan and the Republic of Congo just to name a few. (Connor & Sepúlveda 2014)

LOWER-MIDDLE INCOME $1,026 TO $3,995		
Angola	Indonesia	Philippines
Bangladesh	Kenya	São Tomé and Principe
Bhutan	Kiribati	Senegal
Bolivia	Kyrgyz Republic	Solomon Islands
Cabo Verde	Lao PDR	Sudan
Cambodia	Lesotho	Swaziland
Cameroon	Mauritania	Timor-Leste
Comoros	Micronesia, Fed. Sts.	Tunisia
Congo, Rep.	Moldova	Ukraine
Côte d'Ivoire	Mongolia	Uzbekistan
Djibouti	Morocco	Vanuatu
Egypt, Arab Rep.	Myanmar	Vietnam
El Salvador	Nicaragua	West Bank and Gaza
Ghana	Nigeria	Zambia
Honduras	Pakistan	Zimbabwe
India	Papua New Guinea	Sri Lanka

Table 2 Lower-middle income countries

In the National consensus report, there are clinical practice guidelines in eight domains of care which are listed in table 3. These are structure and process of care, physical aspects of care, psychological and psychiatric aspects of care, social aspects of care, spiritual, religious and existential aspects of care, cultural aspects of care, care of the patient nearing the end of life and ethical and legal aspects of care. Because the health care has been reformed, there were important parts of palliative care that were developed as a strategy of measuring quality. In this paper, the emphasis will be on domain 5 the spiritual aspects of palliative nursing care. (Scott, Thiel & Dahlin 2008 p. 15-21)

Eight Domains of Care	
Domain 1: Structure and processes of care Domain 2: Physical aspects of care Domain 3: Psychological and psychiatric aspects of care Domain 4: Social aspects of care	Domain 5: Spiritual, religious and existential aspects of care Domain 6: Cultural aspects of care Domain 7: Care of the Patient nearing the end of life Domain 8: Ethical and legal aspects of care

Table 3 Eight Domains of Care

Domain 5 has changed throughout the years to include a definition of spirituality. At the same time, there is great importance of interdisciplinary responsibility and teamwork of spiritual situations. While simultaneously stressing interdisciplinary responsibility and collaboration in assessment and management of spiritual issues and concerns, there is emphasis on the use of an appropriately trained chaplain. Requirements for staff training and education in spiritual care are described. Finally, the domain promotes spiritual and religious rituals and practices for comfort and relief. (Scott, Thiel & Dahlin 2008 p. 15-21)

Palliative care nurses need to understand the range of the spiritual component, whether it is ritualized or not, and how its impact affects the care. In addition, they need to collaborate with spiritual care providers and integrate the expertise of their chaplain and spiritual leader colleagues. (Scott, Thiel & Dahlin 2008 p.15-21)

Palliative nursing care is a broad phenomenon and as a result it was narrowed down to contain only the spiritual viewpoint of palliative nursing care skills. However, palliative nursing care still affects people globally. Seok et al (2018) suggests that global is defined as the following: "Relating to the whole world; worldwide." It continues to mean that there are issues that cross through countries, borders and neighbors which affects health of all people. There are many factors, problems and solutions globally that rules, laws, regulations and policies are involved in. (Seok et al. 2018 p. 893-901)

Another definition by Koplan et al (2009) says that health around the world as in the global viewpoint to palliative care "involves many disciplines within and beyond the health sciences and promotes inter- disciplinary collaboration; and is a synthesis of population- based prevention with individual-level clinical care". (p. 1993) In this report, low- and lower middle-income countries are the main areas of focus globally.

One of the most used definitions is that global health is "the collaborative actions taken to identify and address trans-national concerns about the exposures and diseases that adversely affect human populations." (Koplan et al 2009 p. 1993-1995) These definitions and meanings are imperative to be used in this study since millions of lives are affected by health issues around the world. Palliative care is only but a miniscule part of global health. Nevertheless, it is important and touches every person's life at one point in their lifeline. (Davies & Higginson 2004 p. 14)

2.2 Principles of palliative care as part of nursing care

A few principles of palliative care include the fact that it encompasses the whole person which includes their families or loved ones. It does not focus just on the severe disease but more importantly on the quality of life that is left for that person. The side effects as well as the symptoms are treated as rapidly as possible. Social, psychological and spiritual issues and problems are also important principles that are part of palliative nursing care. (Seok et al., 2018) Palliative care can also be referred to as comfort care, symptom management and supportive care. Palliative care can be given in different nursing environments such as a long-term care home, hospital, hospice home, at the patient's own home or an outpatient clinic. (Davies & Higginson 2004 p. 14)

Usually when there is a diagnosis made of cancer, palliative care is presented as an option. Palliative care concentrates mostly on taking care of the person's symptoms which are pain management and ensuring that the quality of life is high. (Kathryn & Jacobsen 2019 p. 326) Unfortunately, palliative care is an abandoned area of care when considering low and lower middle-income countries. The main reason for this is that there are other areas of care that are of utmost urgency for example child health and maternal issues. (Lankester & Grills 2019 p. 472-473)

Another reason for the ignored care of palliative cases is that fewer people in low and lower middle-income countries would survive to live to an older age and a longer life. Palliative nursing care is a problematic area that demands proper training and medication of the best kind. The only way that palliative care can be implemented is with good care teams, availability to medications that tackle the symptoms of the patient and also a barrier free way to the hospital. (Lankester & Grills 2019 p.472-473)

When the environment is of poor quality with few resources, the nurses in charge can help the patients and their families by sharing knowledge with them and teach them necessary skills to take care of the patient. Giving hope, showing compassion and advising about coping mechanisms are ways that the nurse can empower both the patient and their families. (Lankester & Grills 2019 p. 472-473)

The World Health Organization (WHO) defines palliative care as “an approach that improves the quality of life (QoL) of patients and their families facing problems associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual”. This definition is what has been used in this study because it has the word “spirituality” in it and because it exemplifies how people living in low- and lower middle-income countries connects issues of spiritual and religious traditions to death in their own cultures. (Lankester & Grills 2019 p.472-473)

Nursing in palliative care focuses on helping the person and their families to cope with a serious life-threatening illness while relieving pain and other symptoms. It makes the quality of life better and higher ultimately maintaining the dignity of the person until the end of their life. The other terms that can be used to mean palliative care are hospice, terminal care, supportive care or end-of-life care. (Lankester & Grills 2019 p.472-473)

Palliative care takes into consideration all areas of the holistic human being. These includes medical, nursing, social, cultural, psychological and spiritual. The main idea of the principles is that the palliative care is of the utmost highest quality and does not change no matter what the person’s educational level, social status, illness, creed or culture. (Lankester & Grills 2019, 472-473) The perspective of the study was looked at as the patient in holistic care.

Holistic care includes all aspects of the human being which are their physical self, mental wellbeing, emotional wellbeing and spiritual needs as well as wellbeing. For the patient to be cared for in a holistic way, nurses put the patient in the middle of the palliative nursing care as a main role. The spiritual perspective and the holistic care are connected and work together well in this study. Holistic care sees the patients as spiritual explaining that the spiritual wellbeing and needs cannot be disconnected from the other domains. (Thornton, 2013)

Nurses and others who are involved in palliative care need to have suitable attitudes and principles where a person has a death with dignity. Attitudes which include care, empathy, compassion and sensitivity are noticed by people who are under palliative care. The

care giver must show real concern for the person, not just the medical issues. There should be no judgement passed for the person in any area of intellect, ethnic origin, religious beliefs or personality. The consideration of individuality is recognizing that the person is a unique individual and they are not put into categories of their disease. (Lankester & Grills 2019 p.472-473)

The cultural considerations include ethnic, racial, religious and other cultural factors which may be different to a nurse's own culture. Nevertheless, those differences must be respected, and the care must be planned where culturally sensitive issues are addressed. Consent in written form must be given before any treatment takes place. Decision making must be shared between the doctor and patient, informed consent and privacy in medical issues must be assessed. (Sumser, Leimana & Altilio, 2019)

In palliative care, the patient and family members can choose where the care takes place. They discuss whether the care will be at home, in hospital, in a care home or hospice care. There must always be good open communication between all the professionals who are part of the patient's care. Discussion of the different kinds of needs are done with the family members as well as the patient because the nursing implementation is essential. (Sumser, Leimana & Altilio 2019 p.122-147)

Figure 3 Needs of palliative care patients

The International Council of Nurses (ICN) states that nursing care is made up of independent care of people of various ages, races, groups, society, family, as well as, the healthy and the ill with teamwork between many professionals. Nursing involves health promotion, prevention of illness and the care of ill, disabled and dying people. Advocacy, promotion of a safe environment, research, participation in shaping health policy and in patient and health systems management and education are also key nursing roles. (International Council of Nurses. 2012, The ICN Code of Ethics for Nurses. Available from: http://www.icn.ch/images/stories/documents/about/icncode_english.pdf Accessed 30.9.2017)

According to the Social Policy Statement of Nursing, nursing is the "protection, promotion, and optimization of health and abilities, prevention of illness and injury, alleviation of suffering through the diagnosis and treatment of human response, and advocacy in the care of individuals, families, communities, and populations." Nursing care includes not only disease management but also attention to physical comfort, and the recognition that patients' well-being also comprises psychological, interpersonal, and spiritual dimensions. Nurses should have the knowledge and skills to manage pain and other distressing symptoms for patients with serious or life-limiting illness, and to work with patients and their families in palliative and end-of-life care decision-making. (Sumser, Leimana & Altilio 2019 p. 122-147)

Furthermore, the definition of nursing has been expanded to being mainly the actions that assist with caring the physical self, supporting the emotional aspects of the sick, wounded, helpless, vulnerable and dying patient. Nurses are responsible of rehabilitating, restoring, rebuilding and maintaining individuals' psychological, physical, spiritual, social and emotional health. These responsibilities and actions have the factors of palliative nursing care within them. The main needs of palliative patients are explained further in the next section. (Connor & Sepúlveda, 2014)

2.3 Needs of palliative care patients

Sumser et al. (2019) state that there are many needs that patients under palliative care have that can be taken care of. Firstly, physical symptoms such as pain, fatigue, loss of

appetite, insomnia, anxiety, restlessness, vomiting, nausea and shortness of breath. Secondly, emotional needs and ways how to cope are addressed. There are many emotions that come with the information of devastating news of an incurable disease. There may be anger, depression or fear and these are important for nurses to notice and treat.

Then the spiritual needs exist where the families, patients and other caregivers try to deepen their own meaning of their lives in the world. Spiritual beliefs and faith may become even more important by bringing the gap closer and try to find a sense of inner peace. Also, acceptance of their fate can be reached through an agreement or prayer to the heavens or whatever that person believes in. (Sumser, Leimana & Altilio 2019 p. 122-147)

The needs of the families and caregivers are also an important part of palliative care. They have questions, fears and needs just as the patient has. There may be many feelings from anxiety to overwhelming exhaustion, stress, desperation and tiredness. needs. Family members are an important part of the person under palliative care. The health and worry of the family members and friends need to be taken into consideration. (Sumser, Leimana & Altilio 2019 p.122-147)

Practical needs such as finances, legal issues, insurances and employment have to be handled. By building a trusting relationship will help the nurses discuss the goals of the palliative care with the patients and family and friends. The nurses can assist with discussing about advance directives and make communication better and open between the patient and family and care team. (Sumser, Leimana & Altilio 2019 p.122-147)

3 SPIRITUALITY

Puchalski, Dorff & Hendi (2004) define spirituality as “that which allows a person to experience transcendent meaning in life. This is often expressed as a relationship with God, but it can also be about nature, art, music, family, or community—whatever beliefs and values give a person a sense of meaning and purpose in life”. (p. 689-714)

When referring to “spirit”, it means the life force energy of unconditional love that connects all of creation. The root of the word comes from the Latin word spiritus which means breath. Spirituality is a concept that makes us think that our physical being is

separate from us and that it is not restricted to a specific religion. (Puchalski, Dorff & Hendi 2004 p. 689-714)

In short, spirituality is the core of a human being and of a person. It gives a purpose to a person's life and helps in achieving a feeling of being connected to say the universe, nature or god. Most importantly in connection to this study, it is an essential part of palliative care as the definition by the WHO has been established. Spirituality is associated with a person's well-being and this is strongly linked with a person's QoL. (Puchalski, Dorff & Hendi 2004 p. 689-714)

There is no strict definition for spirituality but instead it changes according to the setting that it is used in. In this report, spirituality is defined as "that which gives meaning to one's life and draws one to transcend oneself. Spirituality is a broader concept than religion, although that is one expression of spirituality. Other expressions include prayer, meditation, interactions with others or nature, and relationship with God or a higher power" (Puchalski, Dorff & Hendi, 2004).

Puchalski, Dorff & Hendi (2004) also elaborate that spirituality speaks to the idea of a process or journey of self-discovery and of learning not only who one is, but also who that person wants to be. Spirituality is personal, but it is also rooted in being connected with others and with the world around the person; it often embraces the concept of searching and moving forward in the direction of meaning, purpose, and direction for the person's life. In this paper, it is that definition which will be used when writing about spirituality.

Broader definitions of spirituality point to that which helps to give meaning or purpose to one's life. While spirituality can find its expression in religious observance, it may also be experienced and expressed in the broader context of interpersonal relationships, cultural interactions, or interface with nature. (Puchalski, Dorff & Hendi 2004, 689-714) Spirituality is a dynamic, evolving process, one that impacts and is impacted by an individual's life experience.

4 RELIGION

There are many different religions in the world where mostly have paths for people to follow in order to find eternal life or a deeper truth and love. (Dow, 2007) People can decide themselves if they belong to a religion, if they belong or believe in anything. Due to family traditions, personal reasons, influence or experiences in life are reasons why people choose the religion they want.

There are differences between spirituality and religion. One definition of religion states that it is "a subset of spirituality, encompassing a system of beliefs and practices observed by a community, supported by rituals that acknowledge, worship, communicate with, or approach the sacred, the divine, God as is believed in Western cultures, or ultimate truth, reality, or nirvana as is in Eastern cultures." (Dow, 2007)

Religion may well be one way in which people express their spirituality, but it is not the only way. Religion is more focused on systems or social institutions of people who share beliefs or values. Research shows that nurses often use the terms spirituality and religion to have the same meaning. It is very important to realize that not all patients are religious. Patients may have other connections to their religion through nature, set of beliefs or relationships. (Dow, 2007)

Another definition suggests that religion is "a social structure, created by humans, based on a system of beliefs, attitudes, and practices. Many religions have narratives, symbols, traditions and sacred histories that are intended to give meaning to life or to explain the origin of life or the Universe. The ideologies of each particular religion determine the ethics, religious laws, and preferred lifestyle of its followers." (Zamer & Volker 2013 p. 396)

There are about 4,300 religions of the world. This is according to Adherents which is an independent, non-religiously affiliated organisation. It keeps track of the number and size of the world's religions. (Zamer & Volker 2013 p. 396) Religions are divided into churches, cultures, denominations, congregations, movements, religious bodies, tribes and faith groups. Nearly 75 per cent of the world's population practices one of the five most influential religions of the world. (Zamer & Volker 2013 p. 396) These are Christianity, Islam, Hinduism, Buddhism and Judaism. Christianity and Islam together are two

of the most widely spread religions globally. They comprise of more than half of the world's population.

The world's largest religions and their number of believers are Christianity with 2.1 billion, Islam with 1.3 billion, Hinduism with 900 million, Buddhism with 376 million, Sikhism with 23 million and Judaism with 14 million. (Zamer & Volker 2013 p. 396) The following sections will explain and elaborate further on the definitions and aspects of the different religions of the world.

4.1 Christianity

The teachings in Christianity tell about ethics and one's own morality. They say that people in general including nurses must respect each patient equally and fully. Each patient is a worthy human being and deserve a death with utmost dignity. The patient is the one who starts the trusting relationship by looking for nurses that can help. The nurses are important by easing pain and suffering of the patient. As the saying goes "Love thy neighbor", the nurses show their response to the call of the patient in distress. (Zamer & Volker 2013 p. 396)

Christianity teaches that people have been created in the image of God, even with all their faults, sins, wrong doings and misfortune and this is believed to be true about people even at the end of their life. Even when the person is old or has a serious sickness, the human person is still valuable and important. (Zamer & Volker 2013 p. 396) This is taught in Christianity to encourage Christians to take care of the terminally ill and dying human person. The teachings present the reflection that death is a consequence of sin and is only a temporary separation of body and soul. The nurse working in a palliative care unit should be aware that the patients may see their illness and death as punishment alongside feelings of guilt. (Zamer & Volker 2013 p. 396)

Christians believe that the soul goes to the afterlife and after being judged by Christ, goes to Heaven or Hell. Nurses should be knowledgeable that a good Christian death means being spiritually prepared, resolving any conflicts, forgiving and being forgiven and reconciling sins. The dying may wish for a last rite by a priest or a minister, which may include praying, reconciliation of sins and Holy communion. (Zamer & Volker 2013 p. 396) Christianity tries to give the dying person spiritual help, aid, comfort, forti-

fying the soul and making it possible to join the person with Christ. Ultimately, it strives to help the patient meet death with peace and tranquility. (Zamer & Volker 2013 p. 396)

4.2 Islam

Islam is a religion with 1.3 billion believers. In Islam, some patients may see their pain as a punishment or testing their loyalty to their faith. In order to prove themselves, the patients may in some cases refuse pain relievers and medicine to show they are ready to suffer for their faith. This belief comes from a saying of the Prophet Mohammed which hints at difficulty and pain as a way to expiate sins. As a result, some patients may be reluctant to take pain relief. Another reason some might refuse strong pain medication is that it may slow down or postpone death. (Sarhill, Mahmoud & Walsh 2003 p. 34-37)

In Islam, death is foreseeable, certain and happens only through the commands of God. It also states through its commands that there would be a suggestion for life after death. Death should not be something for the person to struggle against or avoid. Instead, it should be known to be a part of the plan by God. (Sarhill, Mahmoud & Walsh 2003 p. 34-37) When death is nearing, believers pronounce the Faith of Testimony. This short ritual is important because it tells us that the person's death is not the end of him or her, but it is then when it is possible to enter the world of the divine with the right kind of attitude. Death is unpredictable, can occur at any moment, so Muslims should be prepared for death. Death is only a gateway from this short life and onto a life of immortality in the afterlife. (Sarhill, Mahmoud & Walsh 2003 p. 34-37)

Muslims believe that palliative care delays death and stalls a person's fate and does not prolong life. (Sarhill, Mahmoud & Walsh, 2003) When death is soon upon the patient, Islam teaches that the person is to die without any bigger shows of courage or dramatic measures. Muslims allow the administration of medication and any use of technology that enhance the quality of life for the patient during the time they are alive. (Sarhill, Mahmoud & Walsh 2003 p. 34-37)

Simultaneously, there should not be any steps taken to slow down the unavoidable death. It is allowed to withdraw from care in two situations in Islam. (Sarhill, Mahmoud & Walsh 2003 p. 34-37) The first is when the patient is diagnosed with brain death. The

second is when the current treatment is not curing the patient but only prolonging a natural death. (Sarhill, Mahmoud & Walsh 2003 p. 34-37)

4.3 Hinduism

Hinduism is made up of 900 million believers and it includes a wide variety of religious traditions that have been diffused throughout India and the rest of the world. (Aslam & Emmanuel, 2010) Still some major parts remain, and these include the primacy of the Vedas, notions of cause and effect called “karma”, a cyclical model of death and rebirth called “samsara” and spiritual liberation called “moksha”. (Van Dover & Pfeiffer, 2011) In palliative nursing care, Hindu patients and family members may be hesitant to get relief for their pain and other physical symptoms because they consider suffering as a type of opportunity to achieve spiritual liberation by burning away karma. (Lawrence & Westhues, 2014)

It is estimated that nearly one million Indians with conditions like cancer die in acute, unnecessary pain because of the lack of palliative care. According to Hinduism, the main religion of India, the end-of-life (EOL) deals with good and bad death (Aslam & Emmanuel, 2010). The WHO definition of palliative care stresses on improving not only the quality of life of patients facing incurable diseases but also their families by providing relief from the pain and suffering that includes the psychosocial and spiritual needs as well. (Lawrence & Westhues, 2014)

A great example of a palliative nursing care system is effective in Kerala (Aslam & Emmanuel, 2010). There are thousands of volunteers who work together by doing simple tasks such as cooking food, helping with household chores or giving a shoulder to lean on. Here the people hope that those dying will not be left alone to die in pain or suffering. There are hundreds of people in Kerala that belong to Palliative Care Societies. Donations of money, even small amounts of rupees, happen regularly to support the societies. (Lawrence & Westhues, 2014)

Spiritually, patients in Hinduism will listen to prayers, cite their personal mantra or travel to a place of religious pilgrimage. When a person is dying, being prepared and aware of their ending will reassure the patient and family as well as help the family when their time of grieving has arrived. (Lawrence & Westhues, 2014)

4.4 Buddhism

There are 376 million believers in Buddhism. Intentions have a very important role in the Buddhist approach too. The fundamental principles of Buddhism align well with issues addressed in palliative care. The notion of suffering is at the heart of the Four Noble Truths, and Buddha's teachings which are called “sutras” encourage contemplation of suffering and death. (Nouvet et al, 2018)

Buddhists believe in an afterlife whereby humans manifest numerous times and in various forms. The ultimate goal is to become fully enlightened and reach nirvana: freedom from the cycle of suffering and rebirth. Many Buddhists commonly practice death contemplations. (Nouvet et al, 2018)

There are rituals, practices and perspectives which may vary in Buddhism. What is very important is the condition a patient is in when they have dies. It means that if they have suffered or been in tremendous pain while dying, then their rebirth back to this world may be unpleasant. Pain relief and taking medication for it may change the way a patient’s mind is working. (Nouvet et al., 2018)

The patient needs to be quite aware and think about virtuous thoughts in order to have a good transition in life to death and have a good rebirth. In Buddhism, death will happen in the home of the patient where the family will be present as well as other relatives, friends and monks. The monks chant and recite sutras to calm the people in the event of death. (Nouvet et al., 2018)

4.5 Judaism

There are 14 million believers in Judaism. Traditional Judaism gives life infinite value, as humans are created in the image of God. Therefore, an hour, a day or a week of life has as much value as a year or ten years. The challenge comes when we need to determine whether we are preserving life or prolonging dying.

There is no obligation to prolong the dying process, it is quite the opposite. Nurses need to ensure that people don't suffer pain, so palliative care serves a very important role in Jewish beliefs. When relieving pain, healing miracles are used in Judaism and palliative nursing care is welcomed as a tool of God’s powers. (Nouvet et al, 2018)

The Torah which is also known as the Five Books of Moses, is a book of the teachings of God. The book tells that humans are able to achieve God's commands in a better way than the angels. Prayers are recited by Jews when death is near. When the patient draws their last breath, nobody is allowed to leave the area because it is a matter of respect to stay with the dying patient and watch as he or she passes from this world to the next place. (Nouvet et al, 2018)

In Judaism, quite similarly to Islam that patients and their loved ones will not accept palliative nursing care since they view it as giving up on the healing of the patient. It also may reveal to them that their faith is not enough to believe that God will help and rectify the care of the dying patient. (Nouvet et al, 2018)

5 AIM AND RESEARCH QUESTION

The aim of this scoping literature review is to assess as well as to write a summary of the existing empirical literature about skills needed in palliative nursing care through a spiritual perspective in low- and lower middle-income countries. Based on the results, the needed work can be done to help nurses and other health care professionals to get more skills to meet the needs of the patients in palliative care. The following research question was asked: what skills do nurses need in palliative care from a spiritual perspective in low-and lower middle-income countries?

6 METHODOLOGY

This scoping literature review investigates the extent of research on a precise subject, which in this report it is about what literature exists on palliative nursing care skills through a spiritual perspective in low- and lower middle-income countries. The type of analysis used was an inductive content analysis to summarize and spread what is known about the topic. (Kumar 2011 p. 400)

6.1 Scoping literature review

As the writer performed a scoping literature review and searched literature on the topic of palliative nursing care from the spiritual perspective in low-and-lower-middle-

income countries, there were no reviews discovered on the specific research question for this study. Nevertheless, there had been studies about different areas in spirituality and nursing.

A method known as a scoping study demands that all the found relevant literature is included. This type of study design is good for a study that has limited previous research because it gives a descriptive review of available research. (Kumar, 2011) Palliative nursing care is a complex subject and has not been studied as much on the spiritual perspective. In addition, there is more space to describe and it is more forgiving on topics that are broader which have not been as comprehensively studied, as it is the case on this topic. (Kumar 2011 p. 398)

A search done systematically with time limitations was conducted through the subsequent electronic databases: CINAHL complete, Academic Search Premier and PubMed. Searches were limited to English language studies and focused on peer-reviewed publications with an abstract available. The reports that were included were reports that had the spiritual perspective in palliative nursing care. (Kumar 2011 p. 255)

6.2 Content analysis

The way in which the analysis of the collected data was done was by using content analysis. This is an orderly, systematic way of explaining phenomena that analyses the data that is collected inside of the scoping study framework (Elo & Kyngäs 2008 p. 109). The main idea of using content analysis is to produce a wide explanation of the phenomenon that is studied by using a coding technique. The gathered data is categorized by being put in a group that has similarities with each other. An approach known as the inductive approach was used in this study because the studied phenomenon is limited and not much has been researched on the topic. (Elo & Kyngäs 2008 p. 109)

There are three stages in content analysis which are preparation, organizing and reporting. The unit of analysis is chosen in the preparation phase and in this case, it was the previous studies about palliative nursing care and spirituality in low-and-lower-middle-income countries. In the organizing phase, the writer aims at comprehending the data by reading and the repeating the reading. Since the inductive approach to content analysis

was used, there was open coding, category creating and abstraction of data (Elo & Kyngäs 2008 p. 109).

Content analysis as a method that has been condemned with little or no rules when analysis of the data is done, resulting as being basic and simple in its technique and lacking in informative statistical analysis. It is still used widely by researchers because the more skillful, analytical and insightful the researcher is, the more detailed the results will be. (Kumar 2011 p. 115)

7 PROCESS OF SCOPING STUDY

There was a framework that was used to make the process of the scoping study easier and sharper to follow. There are five phases in the process that were followed and if they needed to be repeated, then they were. The first step was to identify the research question, the second step was to identify all the relevant studies, the third step was to select the studies to be included, the fourth step was to chart the data to categorize. (Kumar 2011 p. 267) The final step was to summarize and report all the results.

7.1 Identifying the research question

As it is done in any kind of research, there must be a question that the researcher wants to find an answer to. It is here where the research begins. (Kumar 2011 p. 70) Around the research question, the researcher begins finding out a way how to answer the research question. In that same point in time, the aim of the research is then expressed.

Based on previous studies, palliative nursing and spirituality in low-and-lower-middle-income countries are missing or there is very little about the topic. How important they are and what a major role they play in peoples' lives are not emphasized, not understood and are not seen. The spirituality perspectives are disregarded because there are other more acute situations that need the attention of nurses. There is a lack in knowledge and training in palliative nursing care and spirituality. Hence, the writer wanted to study what skills nurses need when caring for palliative patients in low-and-lower-middle-income countries.

The writer wanted to maintain the wide coverage of the research question and the studies included nursing professionals and different kinds of study methods. All the con-

cepts in the scope including palliative, spirituality and religion were thoroughly defined and explained.

7.2 Identifying the relevant studies

There are several key issues to realize when taking on the task of starting a search of literature. (Kumar 2011 p. 105) The writer decided on what terms to look for, which kinds of sources to use, the years of the articles and in what language the articles were written in. In this study, articles published between 2014 and 2019 were used to find relevant studies. There was a search of different kinds of literature which included sources of books, journals, electronic databases and reference lists.

The data of the research was collected systematically. The main tools used were the broad and wide use of materials provided by Diaconia University of Applied Sciences library resources. The analysis method was done through reviewing research articles. The writer had to use technical help when conducting the searches and turned to the university librarian for advice several times on the correct search terms, how to choose the correct databases and to find the correct versions of the articles. (Elo & Kyngäs 2008 p. 109)

The initial search strategy was made through the main databases of Cinahl complete, PubMed and Academic Search Premier. The PICO method was used to decide the topic of research. PICO stands for:

- P---Patient, Problem or Population
- I --- Intervention
- C ---Comparison, control or comparator
- O---Outcome(s)

In this study the population include the patients who are dying. The keywords are patients and dying. The intervention is all the palliative nursing care skills, where the keyword is palliative nursing care skills. The comparison is done between dying with palliative nursing care versus dying without palliative nursing care. The keyword here is dying without palliative nursing. The outcome of interest is death without dignity. The keyword is death without dignity.

Database	Search terms
CINAHL complete	(Palliative care OR end of life care OR terminal care OR hospice care OR comfort care OR palliative therapy) AND (parish OR spirituality OR religion and religions OR spiritual care OR faith OR belief system) AND low-income countries OR developing countries OR developing nations OR third world
Academic Search Premier	Spirituality or spiritual care or spiritual needs AND palliative care or end of life care or terminal care
PubMed	(Palliative nursing care OR end of life care OR terminal care OR hospice care OR comfort care or palliative therapy) AND (spirituality OR religion OR religions OR spiritual care) AND low-income countries OR "developing countries"

Table 4 Search terms per database **Table 4 Search terms per database**

A scoping literature review encompasses several steps. (Kumar 2011 p. 350-355) The first crucial step starts with identifying the research question. Then following the first step is to next establish definitions of inclusion and exclusion data. All the relevant studies within the inclusion data will be searched for using various databases. Whatever is outside the inclusion data will be excluded and not scrutinized further. After that, the author will select studies for inclusion based on the already pre-defined criteria. All the data will be extracted from included studies, then evaluated further and finally the results will be presented and assessed. (Dewey & Drahota, 2016)

There were international databases which were used in the review of literature. These included CINAHL complete, Academic Search Premier and PubMed. There were many keywords used to search the databases as can be seen in table 4. Among a few keywords were: palliative care, palliative nursing, end-of-life-care, hospice care, spirituality, global palliative nursing, religion, and low-income-countries. Since there is much provided on the topic, it is important to outline what can be discovered. (Elo & Kyngäs,)

7.3 Study selection

In this study, the use of both inclusion and exclusion criteria was used even though scoping studies does not need the use of both when deciding on the type of study.

For inclusion criteria, the data had to be related to palliative nursing care skills with a spiritual perspective in low-and lower middle-income countries. They had to be peer

reviewed original empirical research articles or reviews, papers that have used recognizable research methodology and can be replicated. A large amount of different literature sources was used in varied databases in the English language. They had to be published in the English language and between the years 2014-2019 in a global context. (Arksey & O'Malley 2005 p. 25-26)

The exclusion criteria included papers on domains other than palliative nursing care with a spiritual perspective. The papers that did not include empirical research elements such as editorials, letters, news and comments were considered exclusion criteria. Other criteria included the papers being published in a language other than English and publications outside of the study period as well as outside the global context.

Inclusive data	**Exclusion data**
Studies on palliative nursing care	Not relevant to palliative nursing care
Peer reviewed	Not peer reviewed
Published in 2014-2019 in global context	Published outside of 2014-2019
Research studies	Not research studies
Nursing literature	Not nursing literature
Academic journals	Letters, comments, blogs
English language	Not English language
Middle and low income countries	High income countries

Table 5 Inclusion and Exclusion criteria

When searching the three databases, there were not many studies conducted and this limited the selection of studies. (Arksey & O'Malley 2005 p. 25-26) The writer together with the help of the university librarian conducted the search from the databases and only found some relevant articles to be reviewed. When the writer was charting the basic information, there was a discovery that there was not much research conducted on the topic. (Arksey & O'Malley 2005 p. 25-26)

For this search, the same criteria were applied, but some of them at an earlier point in the search. (Arksey & O'Malley 2005 p. 25-26) Most of the relevant literature found through these searches were duplicates from previous searches, and after going through the whole exclusion process, including quality assurance, no additional studies remained. (Arksey & O'Malley 2005 p. 25-26)

7.4 Charting the data

After the chosen articles have been read and re-read, it is then the task of analyzing them. (Arksey & O'Malley 2005 p. 25-26) They are put in a chart and this is the base of the analysis of the data. When the writer uses a common analytical framework for the literature and has gathered the standard information on the literature, it is called a descriptive-analytical method. This is the time when inductive content analysis is applied to make the process more systematized. The studies were read thoroughly many times and repeatedly by the writer to get a picture of the whole study and include all the necessary data into the chart. (Arksey & O'Malley 2005 p. 25-26)

A process of updating the chart and the included information was done as the writer eventually became more acquainted with the articles. The information that was included in the final version of the chart were the author, year, country, title, aim, purpose, key results and conclusion. The chart with all the included data is in Appendix 1. The analysis of the data commenced by collecting the author (s), the year and the country of publication. Furthermore, the aim, purpose, results and conclusion were assembled. The collection of the information included the original terms of the search. (Arksey & O'Malley 2005 p. 25-26)

7.5 Summarizing the data

In the process of a scoping study, there is the making of a summary of the data. There was a three-step method of the data summarization. They were analyzing the data, reporting the results and application of sense to the results. (Aslam & Emmanuel, 2010)

There should be done two kinds of analyses on the literature. A numerical analysis and a thematic analysis should both be present in the results. (Aslam & Emmanuel, 2010) The usage of an inductive content analysis was a method that was implemented in the data analysis. The steps can be seen in table 6.

After the thematic analysis was done, there was an inductive content analysis done. All the data that was relevant was included and read thoroughly to get a clear understanding of the study, its results and conclusions. If necessary, the phase was done again and again. This was a process of six phases: making sense of the data, open coding, coding sheets, grouping, categorization and abstraction. (Aslam & Emmanuel, 2010)

Table 6 Inductive content analysis process

8 RESULTS

There have been few studies about palliative nursing and spirituality in low-and lower middle-income countries. The chosen topic should be researched more to collect sufficient data and results. However, one study in 2009 by Huang, Yates and Prior was conducted in China and Taiwan. It was about the factors influencing oncology nurses' approaches to accommodating culture needs in palliative care. It was about exploring the social construction of cultural issues in palliative care amongst oncology nurses. It resulted in that the cultural needs would be accommodated by the nurses. There would be aspects that would be about the perspectives of the nurses, their realization of cultures, philosophy of care and experiences. (Huang, Yates & Prior 2009 p. 3421-3429)

In the United Kingdom, there was a literature review conducted to explore the concept of spirituality and how it is applied. This was done by Pike in 2011 and four main themes emerged from the literature. They were concept clarification, spiritual caregiving, religion and spirituality as well as nurse education. (Pike 2011)

Another study conducted in 2014 in Iran by several authors was about Iranian nurses' perceptions of palliative care for patients with cancer pain. It was trying to discover the perceptions of palliative care for patients with cancer pain. The results told that the patients diagnosed with cancer have pain and receive palliative care with psychological support, effective communication and physical relief to pain. (Seyedfatemi, Borimnejad, Mardani & Tahmasebi 2014)

In Australia, Ronaldson et al 2012 wrote about identifying and comparing spiritual caring practice by palliative care and acute care registered nurses (RNs), in order to determine any correlation between nurses' spiritual perspective and their spiritual caring, and to investigate perceived barriers to spiritual caring. (Ronaldson et al., 2012) Another study in 2017 by the same writer conducted a study about spirituality and spiritual caring. It mainly dealt with the nurses' perspectives and practice in palliative and acute care environments. They investigated spiritual caring by palliative care nurses and to describe their interventions. As a result, conceptual understanding of spiritual caring was identified. (Ronaldson, 2017)

A study conducted in Brazil by Daronco, Schmid., Cleci, Loro, Bernat and Adriane was done in 2015. It was about palliative care given to cancer patients and the recording of nursing teams perceptions. They attempted to identify nursing teams' perceptions of palliative care towards patients with cancer. There were many kinds of care which were showing attention towards the family members, communication with the patient, attentive listening skills and supporting psychologically and emotionally. All of these tried to achieve a death with dignity, prolong quality of life, providing comfort and relieving pain. (Daronco et al. 2015 p.657-664)

The most relevant study was written by Downing et al. 2016 was about children's palliative care in low- and middle-income countries. It stated that one-third of the global population is aged under 20 years. For children with life-limiting conditions, palliative care services are required. There was 80% of the needs were situated in low- and middle-income countries but the most part were given in children's palliative care that were in high-income countries. The paper reviewed the status of those services in low- and middle-income countries such as Malawi, Indonesia and Belarus. Then did it review the sta-

tus of the extant research in this field. It ends the study by saying that while a lot has been accomplished already in palliative care for adults, there still needs to be time, effort and attention to guarantee that children and young people have the same care. This can be done through education, clinical practice, research and funding. (Downing, Powell, Marston, Huwa, Chandra, Garchakova & Harding 2016 p. 85-90)

In Turkey, an exploratory study about spirituality and spiritual care was conducted by Mehtap in 2018. It was about the nurses and their perceptions of spiritual care. It aimed at investigating various relationships among different factors of care. It explored Turkish nurses' perceptions of spirituality and spiritual care and to investigate the relationship between their perceptions and some variables. While the results of the study indicate that the knowledge of the nurses concerning spirituality and spiritual care was insufficient, it is thought that spiritual aspect of the care services in both vocational education and in-service training should be examined. (Mehtap, Ozdelikara & Polat 2018 p. 1311)

All in all, there were three main themes which came up repeatedly in the findings when analyzed. They are communication, compassion and giving hope.

8.1 Communication

Nursing science is built on the principles of promoting, protecting, optimizing and maintaining a patient’s health and function. Nurses tasks are to alleviate suffering and tending to the actual illness or potential response to illness. Communication is the fundamental element to all aspects of nursing, and this includes palliative nursing. Communication is used to develop the nurse-patient-family relationship. It is used to review the patient references of care. (Thorne, Oliffe, Stajduhar, Oglov, Kim-Sing & Hislop 2013 p. 445–53)

Communication is used to assess physical, psychological, and psychosocial symptoms and in turn to implement nursing care plans. Since palliative care is an interdisciplinary form of nursing, nurses work within multidimensional teams of variety of professionals. As nurses are a common denominator and a steady, continuous presence with the pa-

tients, they have a therapeutic role in the team because they secure quality care through constant collaboration and consistent, honest communication. (Moir, Roberts, Martz, Perry & Tivis 2015 p. 109–12)

A major need of patients was communication. Communication shares information between all the people involved in the care of palliative care patients. A significant amount of communication literature in palliative care is related to physician-patient communication, with most of that literature related only to breaking bad news. Nurses are the constant presence across many different clinical settings, and it is often the nurse who will spend critical time with patients and families helping them to interpret bad news and listening to their emotional responses to such information. (McCarthy 2011 p. 428–41)

Communication is defined as a mutual influence transaction by both communicators which includes healthcare professional and patient/family member instead of being a cold mechanical process of sending and receiving information. There are differences between this approach and previous ones in the palliative care literature are highlighted. There are theoretical and empirical contributions to research in palliative care and death and dying by communication scholars. (Villagran, Goldsmith, Wittenberg-Lyles, Baldwin 2010 p. 220–234)

Communication in palliative nursing practice is not an easy process but instead a highly complicated undertaking. As the other professional skills of nursing, communication demands practice and education. The need for expert communication is universal in nursing care but takes on particular importance during intense times such as serious illness and palliative nursing care. (Roth, Lis, O'Connor& Aseltyne 2017 p. 59–66) Communication is a key intervening variable to reducing suffering of the patients and optimizing the quality of life that the patient has left with their friends and family. As such, engaging a therapeutic communication process is a core ethical obligation of palliative care providers and organizations

There is an ethical framework when nurses communicate with patients and these include sensitivity, confidentiality, empowerment, deliberation, reflection, and mutual respect.

These concepts can guide nurses and other professionals working in palliative care to decide in what situations to use verbal and nonverbal communication with colleagues, patients, and family members. It should be done in a way that maximizes benefit, supports the implementation of moral agency and minimizes harm. (Wittenberg-Lyles, Goldsmith, Sanchez-Reilly & Ragan 2008 p. 2356–65) One must be careful that if there is too much focus on the outcomes of the communication process, then there may be risks of the communication being unnatural, forced and clumsy.
As stated, there was a repeated theme on communication in palliative nursing care. As known already that the globe is aging, palliative nursing care is becoming increasingly important. (Li & Loke 2014 p. 58–65) There was information and data that would give advice for education of the future of nurses. There were needs of the patients that came out from the communication process between the nurses and patients and family.

There was an emphasis of the nurse relieving pain and symptoms as fast as possible. There was an option to sharing feelings if the patients or family wanted to with the nurse. There was need to sustaining self-control, and a need to conclude that the patient had a real purpose and true meaning to being born to this world, existing and dying. (Duggan & Bradshaw 2008 p. 16) There are many kinds of communication skills that are needed in palliative nursing care. There are the basics of communication which include breaking bad news to the patient and families. There was an addressing of emotional reactions and to this the nurses need to offer emotional support.

In order to achieve great communication skills, nurses need to learn and teach them. They must be practiced and expanded. There can be many techniques for effective and compassionate communication with patients and families in difficult conversations about a life-limiting, life-threatening diagnosis, a failure in treatment, or death. Even if a nurse is experienced or if a nurse is just newly graduated, practicing communication will increase the level of confidence and skills. (Li & Loke 2014 p. 58–65)

Communication is about nurse and patient interaction, the way they connect with each other and how the collaboration happens between family members. Communicating is important in adding to the rest of the quality of life that the patients have left in their lives. Spirituality came up as a main domain through communication and is an essential

part how the patient connects with him/herself, the community, the health care team and the rest of the spectrum in their life-threatening disease. (McCorkle, Engelking, Knobf, Lazenby, Davies, Sipples, Ercolano, Lyons 2012 p. 34–42) When communicating either verbally on nonverbally, nurses need use eye contact because it shows that nurse is focused, is connected. shows compassion and is truly present in the communication.

Communication is also being and staying motivated on the care of the patient. There may lots of stress or rush in the workplace full of distractions, but the nurse must help the patient by giving off a picture of calm and total presence. When nurses show interest in the patients lives and share and tell about their own life, it takes the communication to another level. Asking questions, listening, relating to the experiences of the patient and growing a bond with the patient are part of the process of communication. When there are doctors and nurses discussing the care of the patient, it is important to relay the information back to the patient and family members. (Chawla, Blanch-Hartigan, Virgo, Ekwueme, Han, Forsythe, Rodriguez, McNeel & Yabroff, 964–973)

Palliative care is person-centered care, a model that requires patients and families to understand a difficult diagnosis, articulate their wishes, and participate in informed decision making that supports their goals of care. There are communication tools which are necessary to convey and elicit critical information needed to best support patients on their journey through serious illness. Communication and collaboration among healthcare professionals and the interdisciplinary team is especially important in palliative care. There are strategies to strengthen relationships among the team, referring physicians, care coordinators and other professionals, to improve patient outcomes. (Cronin & Finn 2017 p. 140–146)

Addressing spiritual issues at the end of life is considered a core component of quality palliative care by policymakers, researchers, healthcare providers, patients, and their family members. The implications of communicating with patients and family members about spiritual issues are broad and significant, impacting patient distress, well-being, satisfaction with care, and their overall experience at the end of life. (Sinclair & Chochinov 2012 p. 72-78) While the importance of addressing spiritual needs at the end of life has been extolled by many, implementing theory and a growing evidence base

into clinical practice remains a persistent challenge. The way to close the theory-practice gap is by providing a clinically relevant and evidence-based framework for communicating about spiritual issues at the end of life. The mnemonic SACR-D provides healthcare providers with a clinical guide that is person-centered and honors the diverse understandings and experiences of spirituality at the end of life. (Sinclair & Chochinov 2012 p. 72-78)

There has never been a more important and urgent time for nurses to be educated in excellent communication skills. Undergraduate and graduate nursing faculty, as well as continuing education providers and professional development educators, must be familiar with and include current research regarding the importance of excellent communication, provide opportunities in the classroom to have students/staff practice various scenarios, and role model this important skill. (McCorkle, Engelking, Knobf, Lazenby, Davies, Sipples, Ercolano & Lyons 2012 p. 34–42. With many changes occurring in healthcare due to state and federal mandates, patients and their families have questions and concerns about the cost of care, what treatments are available, how treatment will affect their quality of life, and how long they will have to live. All of these questions require excellent communication skills in order to hear, to bear witness, and to address. (Baer & Weinstein 2013 p. 45–51)

Since there is a changing environment of the leaders in palliative nursing and especially the communication aspects, there needs to be discussion about why this is so. The sustainability of financial impacts and the decreasing amounts of decisions made in palliative care are just a couple of benefits within communication in palliative care. As a result, integrated palliative care communication interventions are proposed, requiring attention to communication objectives and patient and family decision points for development and assessment. Measuring how effective the palliative nursing care is, organizing education in communication and creating interventions in communications are a few developmental areas that are able to further the development of palliative communication. Professionals need to be motivated, energetic and innovative in order for the future of palliative nursing care to be of high quality (Deveugele 2015 p. 1287–91)

8.2 Compassion

Compassion, or caring can be viewed as “nursing’s most precious asset” (Schantz 2007 p. 48-55), a fundamental element of nursing care (Von Dietze & Orb 2001 p. 166-174), and as one of the strengths of the profession. According to Torjuul et al (2007), it involves being close to patients and seeing their situation as more than a medical scenario and routine procedures. The politician’s notion of compassion, according to Alan Johnson, features smiles and empathetic care (Carvel 2008). One of the difficulties in considering issues such as compassion is that everyone – patients, nurses and politicians - will have their own personal, subjective definition. Personal definitions fit in with our own view of the world but may have little in common with the views of others.

The art of nursing lies in compassionate care. The nurse assists the palliative patient as he or she responds to the diagnosis of a serious illness, manages treatment, and begins to psychologically cope. Compassion originates as an empathic response to suffering, as a rational process which pursues patients' wellbeing, through specific, ethical actions directed at finding a solution to their suffering. (Schantz 2007 p. 48-55) The term compassion means the sensitivity shown in order to understand another person's suffering, combined with a willingness to help and to promote the wellbeing of that person, in order to find a solution to their situation. This should be a duty in healthcare professionals' daily work.

There are many reasons why compassion in nursing as a professional and compassionate nursing care are so important. Patients who are ill, sick, injured, dying or need in activities of daily living are vulnerable and need help from others especially nurses who are in constant contact with the patients. Nurses need to be sensitive to the vulnerable moments of the patients and build the nursing relationship to put the patients at ease. Nurses provide treatment and care that put patients in uncomfortable positions that they may not have experienced before. Nurses create a trusting environment through compassionate nursing care, they lead with kindness and provide caring in nursing to ensure comfort. (Henderson & Jones 2017 p. 60-69)

Through compassion, the patient’s care and outcomes improve when a good relationship is created because the patient trusts the nurses, respect the nurses, provide feedback and listen to the nurses. Compassionate nursing care has proven to improve patient out-

comes by increasing patient education retention, pharmacological adherence, and treatment attention and understanding. It needs to be emphasized that family members matter. The kindness and the importance of compassion in nursing extend from caring for patients to caring for their families. (Smeets, Neff & Alberts 2014 p. 794–807) There will be moments in palliative nursing where there can be nothing else done for the patient. It is during that time that family members will be going through a turmoil of emotions.

A massive part of being a compassionate nurse is recognizing these moments when the needs of the dying patients have been met but the needs of the family members are increased. It may be as little as getting a cup of coffee or water, getting a blanket or just being present. It is through these actions that make a difference to that other person, which is what caring in nursing is all about. Patients are people, with family and friends, and nurses have to show that everyone that they come in contact with matters. Nurses need to show the family that they recognize the severity of having a loved one in palliative care. (Sturgeon 2008 p. 42-43)

Nurses must be kind enough and caring enough with the patients to do the right thing when it comes to their families as well. When a nurse has people's lives in their hands, it is truly humbling, and the acts are selfless. The decision-making is ethical, it does not discriminate or favor anyone. Patient safety must not be compromised and there is a challenge to honor the wishes of everyone involved. It is the skill of compassionate care that the nurses must practice when facing the responsibility of patients and family members lives. (Shapiro, Astin & Shapiro 2011 p. 15–28)

The more experienced nurse must remember that there are younger nurses observing how to care for the dying patient. They see the nurse as a role model and are setting examples how to be compassionate with the patient and family members. They may copy the nurse or use the skills that they are learning for the future. Taking compassionate care seriously can show the nursing students how to care for the dying patients. (Mathieu 2014 p. 12–3) It is everyone's duty to be kind to each other because compassionate care is not limited only to caring for the patients but also to the other professionals in palliative care.

8.3 Giving hope

Providing support to the family and the patient is about giving honest answers to whatever they may ask. Understanding the individual aspects to the patients hope through certain behaviors and used as tools when meeting patients' and families' needs for hope and which they are comfortable implementing in practice. Hope is a spiritual dimension and gives people a meaning in life. "Without hope, all is lost". It is part of global well-being. (Brady, Peterman, Fitchett, Mo, Cella 1999 p. 417-428)

Healthcare providers as in this case the professionals on the palliative care team can lack in confidence what is the best way to respond to a patient who has a negative prognosis for their life. Family members may wish for a miracle and the patient hopes for a recovery. Von Roenn, Voltz & Serrie (2013) claim that hoping and hope for miracles may show that the patient and family members are in a religious faith group but it may also be a part of spirituality. They have a deep, emotional response when there is an unknown factor in life. It can be a sign of existential stress and distress with everyone involved unsure how to behave and communicate. They are all hoping for a miracle.

Notwithstanding, the hope for a miracle can disturb the family dynamics and the balance of power between the family members and the patient. This can be due to poor communication, lack of conversation, exhaustion or distrust. It is of utmost importance that the health care professional has the skills and knows how to fix the problem. All the related issues of trust, hope, and miracles have to be explored by the nurses, the patient and the family members. (Kylmä, Duggleby, Cooper & Molander 2009 p. 365-377) The nurses have to stay on good, healthy communication with everyone involved even if there are differences in the way of care and the case of hope.

9 DISCUSSION

Even though, there was very little research done on the topic of this report which the writer could find, there has been significant literature in the field of palliative care regarding communication. Several authors have developed or used protocols for breaking bad news. Several authors have proposed that communication skills must be learned and that inclusion of this content in formal curriculum is important. Several authors have ad-dressed the special issues regarding communication with family members. Im-

parting ac-curate information so that individuals can make informed decisions is essential. Studies have shown that there are also differences in communication needs between patients and family members.

As in any sector of health care, communication must be effective, sufficiently informative and above all compassionate. These are also the cornerstones of palliative nursing care if not even more. The vital components of quality communication are the clear and careful clinical assessment with attention being paid to physical symptoms and psychosocial concerns. (Roth, Lis, O'Connor& Aseltyne 2017 p. 59–66) These mean that the health care professional needs to respond to the pain and suffering of the patient, have adequate listening skills to loss and grief as well as recognize ethical and spiritual issues and concerns. Registered nurses are able to react to and provide for patients with these needs by having skillful and varied techniques of communication.

Being a registered nurse by professional, an oath has been sworn. Therefore, the writer of this study has strictly followed the International Council of Nurses "Code of Ethics for Nurses". The Code of Ethics acts as an important guideline in ethics in both clinical practice as well as in education and research purposes. As the research process progressed, the ICN code was followed in order to conduct research that would be valuable in advancing in the future as a nursing professional. The main values of nursing that are connected to palliative nursing care are integrity, respect and trustworthiness. (ICN, 2012)

Kumar (2011) claims that when undergoing a research study challenge, it is ultimate that the topic and research questions are beneficial and pertinent to others. Confident decisions and thorough development of ideas are parts of the criteria of one being thorough with research. In addition, there must also be congruence between all the parts of the research process. (Kumar 2011 p. 30) The writer carefully considered the research question and attempted to conduct a varying search of literature to maintain the amount of literature available on the research topic. (Arksey & O'Malley 2005 p. 19-32)

This study had its limitations. The findings could have been more abundant and their analysis as well. Because of the scarce amount of studies that were analyzed, the find-

ings could have been richer. Notwithstanding the best efforts to include everything relevant in the study, there still may be literature that was missed. (Arksey & O'Malley 2005 p. 19-32)

The writing guidelines by Diaconia and Arcada University of Applied Sciences were followed in the writing format of the report. There was a guide by Arcada University of Applied Sciences (2018) on how to write a thesis and many online resources were used for proper referencing. These guidelines, rules and instructions all add to the trustworthiness of this thesis. As with any research process, trustworthiness and integrity were achieved. Polit and Beck give four main criteria for research to be trustworthy. They include credibility, authenticity, criticality and integrity. (Polit & Beck 2012 p. 580)

Credibility means "confidence in the truth of the data and interpretations of them" (Polit & Beck 2012 p. 585) and this was attained by analyzing data repeatedly, inclusion of all data found as well as results and interpretations derived. Quotes were included to support the idea and phenomenon with supporting sources. The literature was read repeatedly to ensure there was no duplicated data.

The criteria of criticality and integrity include making decisions in a critical manner, self-scrutiny and self-reflection as the process continues onwards. (Polit & Beck 2012 p. 586). There was data comparison and most importantly self-reflection of the writer. A more thorough and organized system of keeping notes, face-to-face meetings and a journal would have been more helpful in this development. A system called Urkund ensures that there is no plagiarism used and this adds to the reliability and validity of the thesis. Research integrity has been carried out throughout the thesis making process.

10 CONCLUSION

Palliative care is an urgent humanitarian need worldwide for people with cancer and other chronic fatal diseases. Palliative care is particularly needed in places where a high proportion of patients present in advanced stages and there is little chance of cure. Ideally, palliative care services should be provided from the time of diagnosis of life-threatening illness, adapting to the increasing needs of cancer patients and their families

as the disease progresses into the terminal phase. They should also provide support to families in their bereavement. Several ways to begin developing a community-based palliative care program could be started by connecting and networking with local hospitals. Also, permission could be asked from physicians to get involved in a palliative care clinician practice. If there are pilots or projects with a health plan, people could get involved in those. (Clark 2000 p. 50-55)

Effective palliative care services are integrated into the existing health system at all levels of care, especially community and home-based care. They involve the public and the private sector and are adapted to the specific cultural, social and economic setting. In order to respond to the cancer priority needs in a community and make the best use of scarce resources, palliative care services should be strategically linked to cancer prevention, early detection and treatment services for both adults and children. (Roth, Lis, O'Connor& Aseltyne 2017 p. 59–66)

Palliative care is still relatively new to national health systems, particularly in low and lower middle-income countries. A public health approach is needed to foster the development of palliative care services and to overcome existing barriers to palliative care development. Significant barriers exist in the lack of clear policies establishing palliative care, lack of educational programs to teach palliative care, lack of essential medications needed to deliver palliative care, and lack of organized programs to deliver palliative care. All these barriers can be overcome. Existing resources are available that can be adapted to individual countries to fill these gaps. What is needed is the will to do so and to recognize that lack of palliative care is a problem that leads to unnecessary suffering for the people who are among the most vulnerable in a society. (Wilkinson, Roberts & Aldridge 1998 p. 13-32)

As nursing care professionals, registered nurses are trained and educated to provide for the patients. There are connections of trust and this means that there is active listening, being supportive in communication and knowing when there needs to be times of silence. The nurses are there to help the patients and families to be courageous to proceed in palliative situations. This means that there should be genuine presence and focus on all the hopes, wishes, fears and stress of the patients and their families.

There is not one person in this world that does not want a most possible peaceful death. The professionals who are part of this unique experience such as registered nurses have the utmost responsibility to promote a death with dignity, a "good death". This means that there is minimal suffering in all aspects of care particularly spiritual well-being and health. There could be several questions that palliative care nurses could ask of the dying person and family. (Clark 2000 p. 50-55)

There would be questions about faith, religion, spirituality and traditions. Nurses must be sensitive to differences between patients and their individual needs in order to plan and implement as death as the patient would have wished. It would be peaceful and go together with what the needs and wishes are of the spirituality of the patient. (Zamer & Volker 2013 p. 390)

One of the most significant connections to all walks of life and the major religions of the world are the customs, traditions, rules, norms and beliefs of suffering in the human race, the experience of death and dying as well as the afterlife. Not only are there religious, status and social issues but also there are traditions and rituals related to the fact of trying to understand life, spirituality and death. (Zamer & Volker 2013 p. 396) As well as the nursing codes and ethics strive for an experience of peaceful death, the major religions of the world attempt to do this by not actively attempting the death process. Rather, the revered texts and teachings of Christianity, Islam, Judaism, Hinduism and Buddhism aim at relieving distressing symptoms at the end of a person's life.

There can be a model built out of available resources which would include inpatient care, home based care, outpatient clinics, day care support and palliative care teams in the hospitals. In it would be different areas of palliative nursing care. They are physical which would include patient care in local hospitals, health centers, private clinics or traditional healers. There would need to be NGO's getting involved and doing health care. The drug supplies would be available from hospital pharmacies and local pharmacy shops. Advice and support would be set up through local doctors, clinicians and nurse as well as local physiotherapists. The National Palliative Care Association would be accessible. (Baer & Weinstein 2013 p. 45-51)

The psychological aspects would be counselling through social worker, trained volunteer, HIV counsellor, patient advocates and others with the same illness. The support groups could be women's groups and youth organizations. There would need to be support from home and at home through family members and volunteers. (Cronin & Finn 2017 p. 140-146)

The spiritual system would be done by individuals including local religious leaders, volunteers from faith communities, social workers and family members. The people can be part of groups such as the faith community which include church, mosque, temple, synagogue, women's groups, hospital visiting team, and children's groups. (Brady, Peterman, Fitchett, Mo & Cella 1999 p. 417-428)

The social part that would support the patients would be the NGOs, FBOs, food supply work, OVC groups, income generation schemes and small loan schemes. Individual professionals to help out with these would be social workers, legal advisors for making will and testaments. Finally, to get everyone involved would include collaboration with community leaders, local schools and colleges as well as community groups. (Martis & Westhues 2014)

Receiving proper training and building a strong management within the community, palliative nursing care can be a service in low-and lower middle-income countries. There can be teams formed who will be trained, competent and knowledgeable in palliative nursing care. They may set up examples for hospitals to follow and provide resources for the communities without the proper resources as well as empowering the community and its families with skills and knowledge. To conclude, there is significance to how death is experienced in the societies, families, health care professionals and cultures through spirituality.

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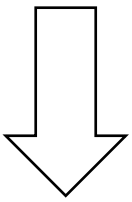
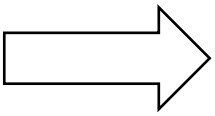
APPENDICES

Appendix 1 Finding search terms

Search terms:	Searching by hand the reference lists and internet browser
Palliative OR palliative nurse OR palliative nursing skills OR palliative nursing care OR palliative nursing care skills OR parish OR hospice OR hospice care OR hospice nursing OR hospice nursing care skills OR terminal care OR terminal care nurse OR terminal nursing care skills OR end-of-life-care OR end-of-life-care nursing OR end-of-life care nurse OR end-of-life care nursing skills OR dying AND spirituality OR religion OR faith OR belief system AND developing countries OR developing nations OR third world OR low income countries CINAHL complete 175 PubMed 5 Academic Search Premier: 180	





The titles and abstracts screened for inclusion/exclusion criteria

300 references excluded:

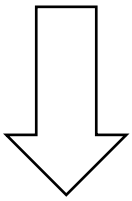
-10 based on the exclusion criteria

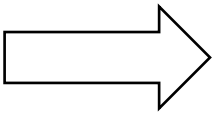
- duplicates

300 possible full-text articles screened for inclusion/exclusion criteria

After titles and articles reviewed for content, 100 articles were selected for more in-depth review

10 articles that fit the above inclusion criteria were identified





8 full text articles included

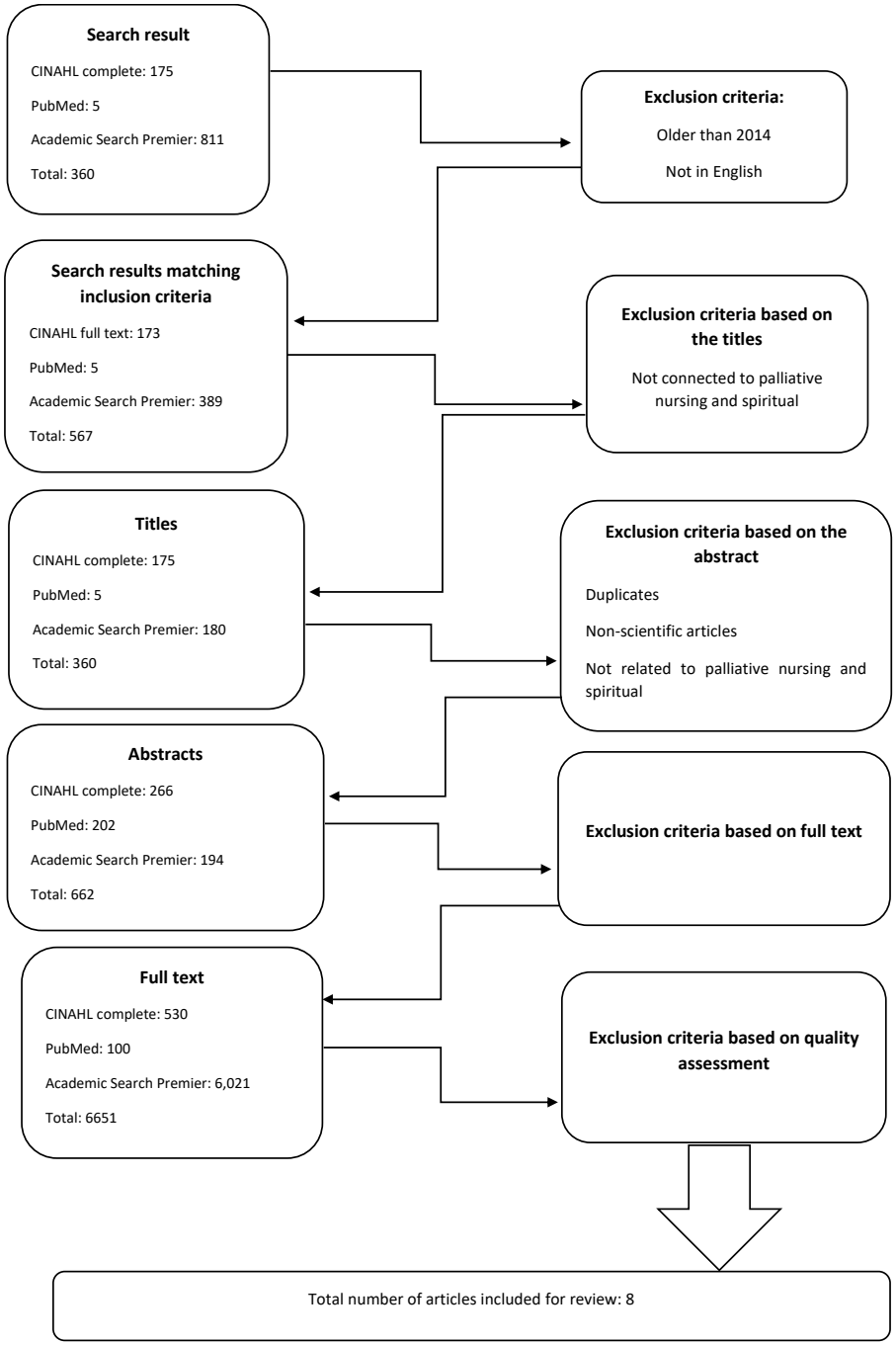
8 full-text articles screened for inclusion criteria and were included for review

CINAHL full text 2 articles that fit the above inclusion criteria were identified

PubMed 3

Academic Search Premier 3

Appendix 2 Data gathering



	Author(s), year, country	Title	Aim(s) and purpose	Key results	Conclusion
01	Huang, Y.L., Yates, P., Prior, D. 2009. China and Taiwan	Factors influencing oncology nurses' approaches to accommodating culture needs in palliative care.	Exploring the social construction of cultural issues in palliative care amongst oncology nurses	The cultural needs would be accommodated by the nurses	There would be aspects that would be about the perspectives of the nurses, their realization of cultures, philosophy of care and experiences.
02	Pike, J. 2011. United Kingdom.	Spirituality in nursing: A systematic review of the literature from 2006–10	Literature review conducted to explore the concept of spirituality and how it is applied.	Four major themes emerged from the literature: concept clarification; spiritual caregiving; religion and spirituality; and nurse education.	Definitions of spiritual care vary, and the concept of spirituality in nursing is still under development. However, until a common language of spirituality is developed, models of spiritual care developed through research involving mainly nursing staff will be difficult for nurses to apply.
03	Ronaldson, S., Aggar, C., Hayes, L. Green, J. 2012. Australia.	Spirituality and spiritual caring: Nurses' perspectives and practice in palliative and acute care environments	Identify and compare spiritual caring	Significant differences were seen between the two RN groups.	Palliative care RNs' spiritual perspectives influenced their spiritual

			practice by palliative care and acute care registered nurses (RNs), determine any correlation between nurses' spiritual perspective and their spiritual caring, and to investigate perceived barriers to spiritual caring.	Palliative care RNs' spiritual caring practice was more advanced and their spiritual perspective stronger; this relationship was positive. Both RN groups identified 'insufficient time' as the most common barrier to spiritual caring practice; 'patient privacy' was also common for acute care RNs.	caring. These nurses were older and more career-advanced than the acute care RNs, which may explain the differences observed. Acute care RNs may benefit from additional support for their spiritual caring and to address perceived barriers.
04	Seyedfatemi, N., Borimnejad, L., Mardani, H.M & Tahmasebi, M. 2014. Iran	Iranian nurses' perceptions of palliative care for patients with cancer pain.	Finding out the perceptions of palliative care for patients with cancer pain.	Patients diagnosed with cancer have pain and receive palliative care with psychological support, effective communication and physical relief to pain.	The sample felt that palliative care for patients with cancer pain must include psychological empowerment, support, and communication as well as physical pain relief.
05	Daronco, V., Schmid P. R., Cleci L., Loro, M. M., Bernat, K., & Adriane C. 2015. Brazil.	Palliative care to cancer patients and the nursing teams' perceptions.	Identify nursing teams' perceptions of palliative care towards cancer patients	There were many kinds of care which were showing attention towards the family members, communication with the patient, attentive	

				listening skills and supporting psychologically and emotionally. All of these tried to achieve a death with dignity, prolong quality of life, providing comfort and relieving pain.	
06	Downing, J., Powell, R., Marston, J., Huwa, C., Chandra, L., Garchakova, A. & Harding, R. 2016.	Children's palliative care in low- and middle-income countries	One-third of the global population is aged under 20 years. For children with life-limiting conditions, palliative care services are required. However, despite 80% of global need occurring in low- and middle-income countries (LMICs), the majority of children's palliative care (CPC) is provided in	Fifteen potentially eligible papers were identified after excluding duplicates and judging the relevance of the studies. The types of study varied: one was a systematic review, one was a narrative literature review, four were supplements or commentaries, four were quantitative studies, two were qualitative studies, two were mixed-method studies, and one was a book chapter. Of these, 12 studies evaluated needs, eight studies examined availability and/or accessibility, one study assessed quality, and one study addressed	The findings demonstrated an urgent need for palliative care in LMICs, particularly with respect to training for health workers and improving accessibility/availability of palliative care including medication and bereavement support. The best practice models showed that strong leadership and effective collaboration with the local government and organizations are essential for success. The quality of pain management and emotional support was poorer in LICs than in HICs. Although this review identified a limited number of studies on

			high-income countries. This paper reviews the status of CPC services in LMICs--highlighting examples of best practice among service models in Malawi, Indonesia and Belarus--before reviewing the status of the extant research in this field. It concludes that while much has been achieved in palliative care for adults, less attention has been devoted to the education, clinical practice, funding and research needed to ensure children and young people receive the	the model. Seven studies mentioned more than one theme. Geographical distribution among the studies was examined. Five studies covered a single country including Malaysia, Mexico, Morocco, Pakistan and Uganda. Nine studies covered multiple countries or specific regions.	palliative care for children in LMICs, the challenges, such as training for health workers and availability of opioid analgesics, were common to different LMIC settings.

			palliative care they need.		
07	Ronaldson S, Hayes L, Aggar C, Green J, Carey M. 2017. Australia.	Palliative care nurses' spiritual caring interventions: a conceptual understanding.	To investigate spiritual caring by palliative care nurses and to describe their interventions.	A conceptual understanding of spiritual caring was identified.	A conceptual understanding of spiritual caring was identified.
08	Mehtap T., A. Ozdelikara and Polat H. 2018. Turkey.	An Exploratory Study of Spirituality and Spiritual Care among Turkey Nurses	This study is aimed to explore Turkish nurses' perceptions of spirituality and spiritual care and to investigate the relationship between their perceptions and some variables.	The average age of the nurses agreeing to participate in the study was 29.38±6.4 and 68.5% of them had bachelor's degree, 62.8% stated that they did not receive training concerning spirituality and spiritual care. 60% of those who stated that they received training on spirituality and spiritual care reported that they received this training during their nursing education. The mean score obtained by the nurses was 2.46±0.5 in spirituality and spiritual care subscale, 3.22±0.5 in religiosity subscale and 2.64±0.5 in	While the results of the study indicate that the knowledge of the nurses concerning spirituality and spiritual care was insufficient, it is thought that spiritual aspect of the care services in both vocational education and in-service training should be examined

				individual care subscale; whereas, total mean score of SSCRS was 2.83±0.3	