PROVIDING A GOOD DEATH;

THE IMPORTANCE OF CULTURALLY SENSITIVE END OF LIFE CARE IN THE ACUTE WARD SETTING

Degree Programme in Nursing
Bachelor of Health Care
Final Project
Spring 2010

Leena Ahvenainen

Metropolia

Degree Programme in	Degree
Degree Program in Nursing	Nursing

Author/Authors

Leena Ahvenainen

Title

PROVIDING A GOOD DEATH: THE IMPORTANCE OF CULTURALLY SENSITIVE END OF LIFE CARE IN THE ACUTE WARD SETTING

Type of Work	Date	Pages
Final Project	Spring 2010	23 + 2 appendicies

ABSTRACT

The purpose of this paper is to highlight the importance of culturally sensitive end of life care in the acute ward setting and show nurses how they can provide culturally sensitive end of life care for their patients. The research question What is culturally sensitive care at the end of life in the acute ward setting, and how can nurses provide it?

Madeleine Leininger's theory of Cultural Care Diversity and Universality has been used to provide a framework for writing this paper. The paper was written by conducting a systematic litrature review was perfromed by using well known electronic databases and manuals search methods. The articles choosen met the six selection criteria as well as answering the research question. The articles were analysed using a method which is based on the method described by Elo and Kyngäs (2008).

During the data analysis process, seven main themes and two sub themes emerged that are a part of providing culturally sensitive end of life care. The seven major themes are; Death and Dying is a Complex Issue, Culture Plays a Part in Determining a Good Death, A Person's Beliefs Affect Their View, Nurses Have a Important Role, There Needs to be Clear Communication, The Definition of a Good Death is Individual, Areas That Need Improvement. The two sub themes are; Shared Aspects of a Good Death and Shared Aspects of a Undignified Death. Each of these themes will then combine to form the patient's own personal world view. It was possible to relate each of these themes to issues that were raised by Leininger in her theory.

Death is and increasingly complex and diverse issue that nurses face today and with the rapidly aging population it is a challenge that acute care nurses will face on an increasingly routine basis. The most important role of the nurse when it comes to providing end of life care is the development and implementation of comprehensive and culturally sensitive end of life care plans in partnership with patients. Once such plans are developed in falls to the nurse to ensure that they are followed, after all it is only by following the wishes patients that have been outlined in such plans can nurses help patients to die a dignified and peaceful death.

Keywords

Culturally sensitive care, End of life care acute hospital

Koulutusohjelma	Suuntautumisvaihtoehto
Terveys ja Hoitoala	Sairaanhotaja AMK

Tekijä/Tekijät

Leena Ahvenainen

Työn nimi

Kulttuurisensitiivinen kuolema: kulttuurisensitiivinen hoidion merkitys elämän loppu vaheen hoitodossa akuutti osastolla

Työn laji	Aika	Sivumäärä
Lopputyö	Kevät 2010	23 + 2 liitema

TIIVISTELMÄ

Tämän esityksen tarkoituksena on korostaa kulttuurilähtöisen elämän loppu vaheen hoidon tärkeyttä akuutti osastolla ja selvittää hoitajille, kuinka he voivat antaa sellaista kulttuurisensitiivinen hoito potilailleen. Tutkimuksen kysymys: Mitä on kulttuurilähtöinen saattohoito osastolla ja miten hoitajat voivat sitä antaa?

Tämän esityksen pohjana on käytetty Madeline Leiningerin teoriaa Cultural Care Diversity and Universality, kulttuurilähtöisen hoitamisen monimuotoisuus ja yleismaailmallisuus. Esitys on kirjoitettu tekemällä systemaattinen kirjallisuushaku/katsaus käyttäen hyvin tunnettuja sähköisiä tietokantoja ja käsikirjoja. Valituilla artikkeleilla oli kuusi valintakriteeriä ja ne vastasivat myös tutkimuksen kysymykseen. Artikkeleita tarkasteltiin käyttämällä toimintatapaa, joka perustuu Elon ja Kyngäksen (2008) metodiin.

Tarkasteluprosessin aikana nousi esiin seitsemän pääteemaa ja kaksi alateemaa, jotka ovat osa . kulttuurisensitiivinen elämän loppu vaiheen hoito. Seitsemän pääteemaa ovat: kuolema ja kuoleminen on monitahoinen kysymys, kulttuurilla on tärkeä osa hyvän kuoleman määrittämisessä, henkilön vakaumus vaikuttaa näkemykseen, hoitajilla on tärkeä tehtävä, kommunikaation tulee olla selkeää, hyvän kuoleman määritelmä on yksilöllistä, parannusta kaipaavat alueet. Kaksi alateemaa ovat: yhteiset näkemykset hyvästä kuolemasta, yhteiset näkemykset epäkunnioittavasta kuolemasta.

Jokainen näistä teemoista yhdistyy potilaan omaksi maailmankuvaksi. Jokaista teemaa saattoi tarkastella Leiningerin teoriassaan ottamia näkökohtia vasten. Jokainen teema tuli esiin myös niissä näkökohdissa, joita Leininger esitti teoriassaan.

Kuolema on enenevässä määrin monitahoinen ja monimutkainen kysymys, jonka hoitajat kohtaavat. Nopeasti ikääntyvän väestön myötä se on haaste, jonka hoitajat kokevat yhä useammin. Kulttuurisensitiivinen elämän loppu vaiheen hoidossa, hoitajan tärkein tehtävä on kehittää ja toteuttaa kokonaisvaltaista ja kulttuurisensitiivinen elämän loppu vaiheen hoito, joka on suunnitelmä yhdessä potilaan kanssa. Kun sellaiset suunnitelmat ovat valmiit, tulee hoitajan varmistaa, että niitä noudatetaan. Loppujen lopuksi on kyse potilaan toivomuksista, jotka on suunnitelmissa selvitetty. Niiden avulla hoitajat voivat olla tukena siihen, että potilaat saavat arvokkaan ja rauhallisen kuoleman.

Avainsanat

Kulttuurisensitiivinen hoito, elämän loppu vaiheen hoito akuutissa sairaala

CONTENTS

1. INTRODUCTION

Today's society is rapidly becoming increasingly multi-cultural, as travel becomes more affordable and accessible. This has increased the need for nurses to be aware of differences among cultures. It has also increased the need for nurses to be educated in how to provide culturally sensitive care in all areas of health care. One of the areas in which the awareness and cultural sensitivity are most needed is when caring for patients at the end of their lives.

The focus of health care professionals has traditionally been on the preservation of life and restoration of health. Hagedorn (2004) points out that in recent years the nurse-patient relationship has as a result become increasingly treatment centred. It is perhaps due to the treatment centred view that, the importance of the spiritual well-being of the patient has been too often ignored or dismissed as being unimportant. The patient's cultural needs are also often ignored when patient care is treatment focused.

Another consequence of this treatment centred view is that, except in specialised departments, the importance of end of life care has often been forgotten. Andrews and Hanson (2003:439) state that "death is indeed a universal experience, but one that is highly individual and personal." The way in which death is experienced is affected by our religious beliefs, culture and experiences; therefore, there is no one universally accepted definition for what constitutes a good, dignified death.

The most commonly accepted definition of a good death is one that is in keeping with the patient's own beliefs and traditions regarding death and dying. The way people view death is highly influenced, not only by their culture and religious beliefs, but also by their previous experiences of death and by the community in which they live.

The only way nurses can provide their patients with a dignified death in accordance with the patient's own views, beliefs and values, is to discuss end of life issues in an open manner with the patient. Mistakes made at the end of life increase the pain and grief experienced by family and friends when a loved one dies.

The purpose of this paper is to highlight the importance of culturally sensitive end of life care in the acute ward setting and show nurses how they can provide culturally sensitive end of life care for their patients. Only through awareness of the cultural and spiritual needs of individual patients can nurses provide them with a good and dignified death.

2. THEORETICAL BASIS

Madeleine Leininger's theory of Cultural Care Diversity and Universality has been used to provide a framework for writing this paper. Leininger (2006) explains that, while working in a children's guidance centre, noticed that children who came from different cultural backgrounds, had different behaviours and needs.

Leininger (2006) states that she came to identify that health care professionals had lack of knowledge regarding different cultures to gain knowledge about cultures, Leininger decided to return to school. It was during this time that Leininger (2006) states that she

first started to develop the theory of Cultural Care Diversity and Universality. While the focus of the theory is on nursing, it can also be used in other areas of health care.

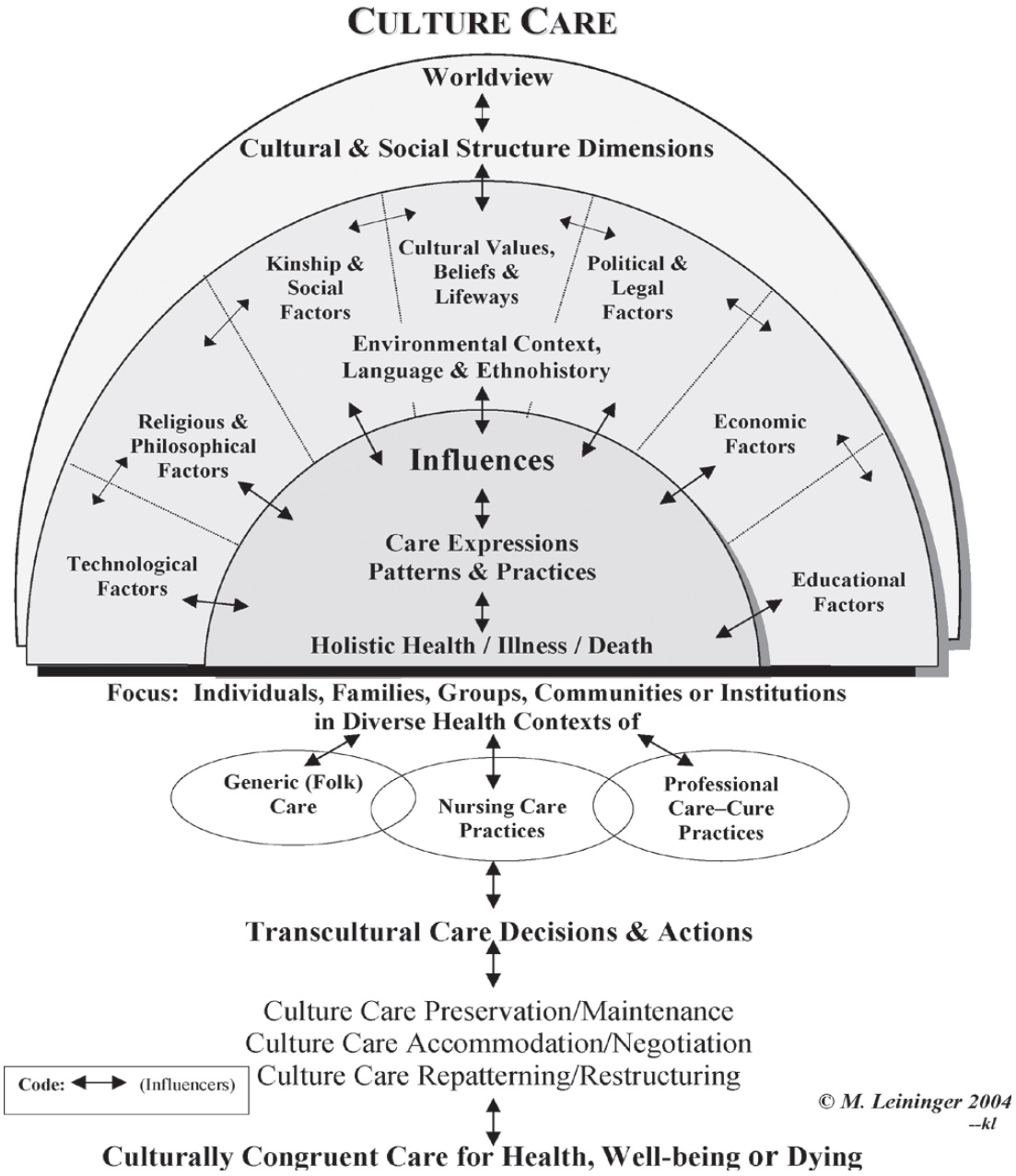
Leininger (2006) had defined Culturally Sensitive Care as being; the providing professional nursing care for the patient while acknowledging and respecting the patient's own cultural beliefs and norms. Leininger (2006) also explains that in many cases religion and culture are closely related. When there is a difference between the care that is required and the patient's cultural beliefs and values, a compromise must be negotiated that satisfies medical staff and the patient.

Leininger (2006) has defined Culture as "patterned life-ways, values, beliefs, norms, symbols and practices of individuals, groups or institutions that are learned, shared and usually transmitted from one generation to another."

Leininger (2006) goes on to state that it is important to pay attention to the culture of the patient in order to provide effective nursing care, explaining that cultural care is influenced by many factors, including religion and technology. It is also important to take into account the fact that cultures change over time as people come into contact with others in society. In this way culture becomes individualised to some extent.

While developing the theory of Cultural Care Diversity and Universality, Leininger (2006:19) also developed six enablers which were "designed to tease out in-depth care and culture knowledge". In researching this paper the Sunrise enabler (see diagram one) was used to gather data.

Diagram One: Leininger's Sunrise Enabler. (Leininger, 2006:25)



By considering all of the domains depicted in the enabler, a complete understanding of the patient's cultural needs can be developed; however, the focus of the research may be on a single domain. In this way this enabler, provides flexibility while still creating a solid framework for research. For the purposes of this paper the researcher focused on the Cultural and Social Structure Dimensions.

Leininger (2002) has stated that the cultural and social dimension combines many different factors to form the individual culture that is held by a person. Some of the factors that Leininger (2002) includes can be seen in the sunrise enabler. Leininger (2002) also considers the role that the physical environment as well as the social environment that a person experiences has on their culture. To describe how the past experiences affect cultural views Leininger (2002) uses the term Ethno history.

3. PURPOSE AND RESEARCH QUESTION?

The purpose of this paper is to highlight the importance of culturally sensitive end of life care in the acute ward setting and show nurses how they can provide culturally sensitive end of life care for their patients.

What is culturally sensitive care at the end of life in the acute ward setting, and how can nurses provide it?

4. DATA COLLECTION

To collect data to provide an answer to the research question it was decided to perform a systematic literature review on research articles that have been written on this topic.

The search for literature was begun by determining the keywords that would be used in searching the database and then by determining the criteria that would be used when selecting the articles.

4.1 Selection Criteria

When selecting the articles, six selection criteria were applied. Selection criteria one through six are described in this section.

The first selection criterion used was that the articles published are research articles, not conference coverage or responses to previous articles. This would ensure that the author of this paper had access to all the information used by the articles author.

The second criterion was that the articles needed a publication date between January 2000 and March 2010. This was to ensure that the information would be the result of recent studies and therefore relevant for today's society.

The third criterion used was that all of the articles needed to be published in the English language. By including articles that were written only in English ensured that the author of this paper would be able to easily read the articles. It also ensured that there would be no misunderstandings would occur during the translation process.

The fourth selection criterion was that the articles needed to be published in nursing or medical journals. The journals could be published in electronic format or in hard copy format. This criterion was chosen to ensure that the articles would be relevant to nursing care and be easily accessible to the author.

The fifth selection criterion required that the articles focus on the importance of culturally sensitive care at the end of life as it applies to all cultures rather than any one specific aspect of dying, religion or culture. This selection criterion ensured that the articles used in this paper were not too narrow in focus.

The sixth selection criterion required the articles to be focused on providing end of life care in the acute ward setting. This selection criterion ensured that the articles would answer the research question.

4.2 Keyword Search

The following keywords were used when conducting the database searches; End Of Life Care, Culturally Sensitive Care.

End of life care can be defined as the care that health care professionals provide during the dying process. The goal of end of life care is to decrease the suffering that a patient experiences due to the disease process. Suffering can take on physical, emotional or spiritual forms and each of these forms need to be relieved when providing quality end of life care.

Culturally Sensitive Care can be defined as providing professional nursing care for the patient while acknowledging and respecting the patient's own cultural beliefs, practices and norms.

The articles were found by searching through the CINAHL, Medscape, PubMed and Ovid databases.

Table One: Keyword Search Table Results.

DATABASE	**KEYWORD**	**RESULTS (No Limits)**	**ARTICLES MEETING SELECION CRITERIA 1-4**
CINAHL	Culturally Sensitive Care	56	9
	End of Life Care Acute Hospital	0	0
PubMed	Culturally Sensitive Care	1,591	20
	End of Life Care Acute Hospital	535	1
Medscape	Culturally Sensitive Care	209	150
	End of Life Care Acute Hospital	1,302	134
TOTAL		3,693	314

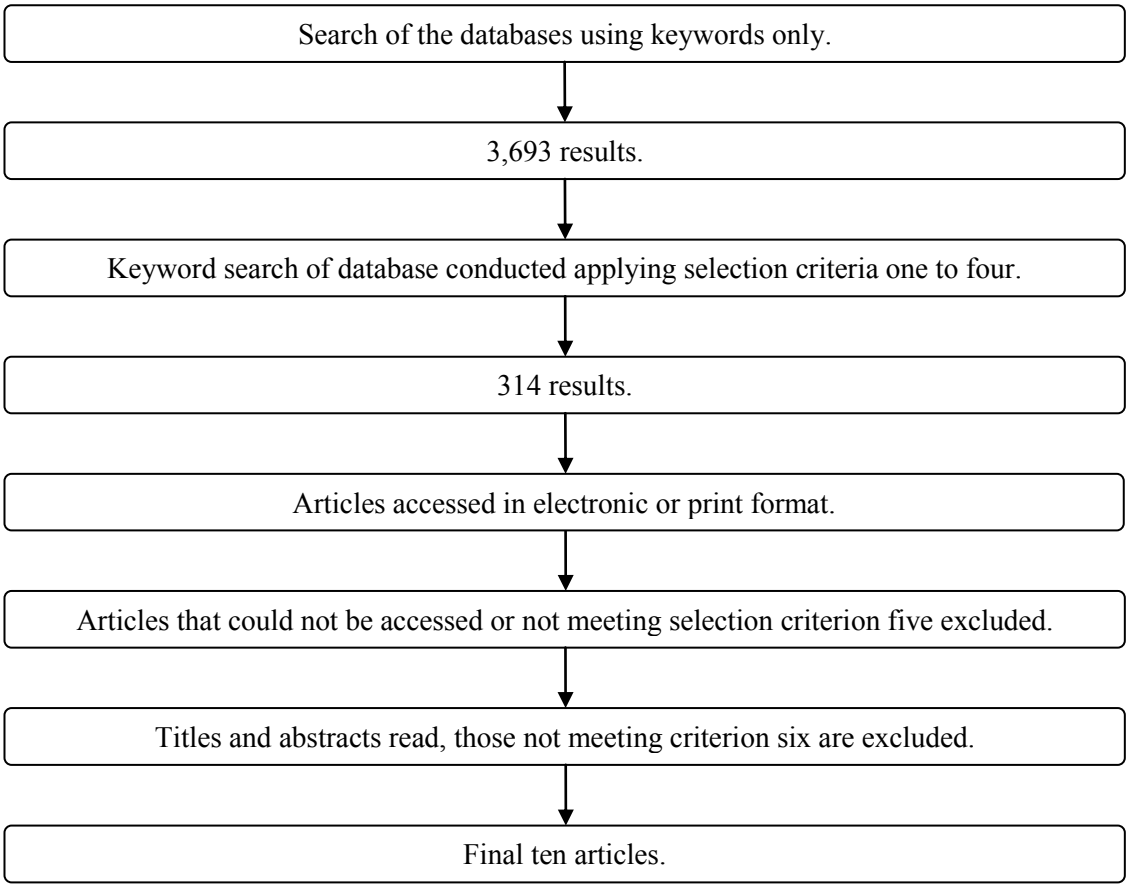
To begin the database search, each keyword was entered into the database without any limits; this resulted in 3,693 possible articles. In order to reduce this number of articles, the search was re-run, this time with selection criteria one to four in place. This reduced the number of possible articles to 314.

Of these 314 articles, eight were not accessible in electronic format. Of these eight it was possible to access four via printed journals, and of these four only two met the selection criteria. It was not possible to access the remaining four articles.

Selection criterion five was applied to the 314 accessible articles. This further reduced the number of results. The abstracts and introductions of the remaining articles were read, and the final ten articles were selected. This selection process is shown in diagram 2.

All of these ten articles, which have been used in writing this paper appeared in the results of more than one search.

Diagram 2: Article Selection Chart.



5. DATA ANALYSIS

To analyse the data that was gathered, a deductive content analysis was performed, the analysis method used was based on the method described by Elo and Kyngäs (2008).

The first step in performing this analysis was to read the articles in order to reach a basic understanding of the article. Next, the articles were read a second time. It was during this reading that the results were recorded in the article summary table (appendix one). The articles were then read a third time to ensure all data was gathered and recorded.

Next the data from the article summary table was read and the points that had similar ideas grouped into themes. It was found that there were seven major themes and two sub themes. These seven major themes and two sub themes were then given names based on their shared ideas (appendix two).

Throughout the analysis process the sunrise enabler developed by Leininger was used to guide the research so that all the different aspects that make up culturally sensitive care would be considered. The area that received the most focus in this paper was the Cultural and Social Structure Dimensions that are discussed by Leininger.

6. FINDINGS

During the data analysis process, seven main themes and two sub themes emerged that are a part of providing culturally sensitive end of life care. Each of these themes will then combine to form the patient's own personal world view. It was also possible to connect each of the themes to factors that Leininger displays in the sunrise enabler.

6.1 Death and Dying is a Complex Issue

The first theme that emerged from the results was that death and dying are complex issues. This theme relates to several of the factors that Leininger highlights in the sunrise model of her theory. The factors most closely related to this theme are the kinship and social factors, nursing care practices and political and legal factors.

Costello (2006) raises the idea that death today is an increasingly complex and diverse issue that nurses face. Mcsteen et al (2006;259) agree and go on to state that the "ethically and morally charged issues that surround dying and death that pose some of the most challenging opportunities for nurses in their role as advocates." Thacker (2008) points out that during the twentieth centaury, due to the advances made in medical technology, the practice of advocacy and end of life care has changed drastically.

Toscani et al (2003) put forward the idea that in the past it was easier to accept death as the loved one who was dying had been placed in a scenario which was accepted by all members of the society, in this way it was possible to find a meaning for death. As medical technology advanced, this natural acceptance was forgotten. For nurses today, however, Thacker (2008; 183) points out the "demand for end of life care will continue to grow as our elderly population grows".

As this elderly population grows, the number of patients who suffer from chronic illnesses will increase. These patients will be cared for in all areas of heath care including in acute care wards. Thacker (2008) found that acute care nurses are caring for dying patients on an increasingly routine basis. Thompson et al (2006; 170) state that "providing quality care to dying persons has become a major, political, social and healthcare concern". This is most likely due to the increasing disparity that exists between the way patients die and the way they wish to die.

Costello (2006; 594) has found that "the ideology of a good death has its origins in the early hospice movement", Toscani et al (2003) noted that many patients' and their families' will have a wide set of rites, acts and behaviors that they view as being important. The meanings behind some rituals that the family performs may have been lost as they have been passed down through the generations, but this does not lessen their significance.

The death of a loved one at any time is an emotional event. Lobar et al (2006) found that the age of the patient and the manner of the patient's death can significantly affect the ability of the family to accept the death. Toscani et al (2003) add that the scene of a patients' death is one that forms lasting memories. Crawley et al (2002; 677) state that "community and cultural ties may provide a source of great comfort as patients and families prepare for death." Toscani et al (2003) add to this that it is important for patients to see that all members of staff view death a being a natural event

6.2 Culture Plays a Part in Determining a Good Death

The second theme that emerged was that cultural background will play a large role in the way that a patient defines a good death. This theme is relates completely to the cultural values, beliefs and lifeways section of Leininger's sunrise model.

The cultural background of the patient will have an effect on the meaning of death, which in turn will lead to the way in which end of life care plans manage symptoms and the way grief is expressed by those closest to the patient.

In the world today there are many thousands of different cultures that are continually evolving and changing. This makes it impossible for nurses to become familiar with each of them; they do, however, need to be aware and acknowledge the existence of these cultures. Crawley et al (2002; 676) have stated that all medical professionals, including nurses, need to be "aware of how culture shapes patients' values, beliefs and world views". A common mistake made by medical professionals is to view cultural and religious needs as being synonymous rather than being closely related. Lobar et al (2006) found that there is much difficulty when it comes to separating if it is the patient's culture or religion influencing the decisions that are being made.

The cultural needs of a patient will cover many different needs, only one of which is religion. Narayanasamy (2003; 190) points out that "cultural and religious needs are integral to overall wellbeing". Narayanasamy (2003) found that the most common cultural needs that are recognised by nurses are those needs that are related to religion and diet. Narayanasamy (2003; 194) goes on to state that while these are important, effective cultural care will recognise all of the patient's cultural needs, which include "religious practices, diets, communication, dying, prayer needs and cultural practices."

It is also important to remember that every culture will have different needs when it comes to personal space and appropriate communication; for example, in some cultures, treatment decisions are made as family and discussions are held with family members rather than with the patient. The cultural background will also influence who will be involved in the patients' care at the end of life.

According to Crawley et al (2002; 674) the social and cultural background of a patient will "shape end of life preferences" it is for this reason that a patient's feelings towards life support and withholding/withdrawing treatment will vary greatly. In some cases the views that are held by a patient will seem contradictory to nurses.

Crawley et al (2002; 677) found that the "influence of culture on meaning and experience of death and dying may be applied to fundamental domains of end of life care" this includes not only such things as the way symptoms and pain are managed but the importance of religion and culture, as well. It is important for nurses willing to help families and patients at the end of life to complete rituals so that beliefs are respected.

These rituals have many meanings and will often be part of ceremonies. According to Lobar et al (2006; 44) "grieving and death rituals vary across cultures and are often heavily influenced by religion". Culture will also play a role in the way that the family members of the dying patient will express their grief.

6.3 A Person's Beliefs affect Their View

The third theme that emerged was that the spiritual beliefs that are held by a person will affect their view and experience of death. This theme relates to the religious and philosophical factors of Leininger's theory.

Daaleman et al (2006) state that one of the things that patients and their families most desire form nurses is the acknowledgement of spiritual needs and support in meeting those needs. As a result Daaleman et al (2006) recommend that nurses give attention to the emotional, social and spiritual needs of patients instead of focusing exclusively on their physical needs.

Toscani et al (2003) and Lobar et al (2006) found that the belief or non-belief in a soul and what happens to this soul after life played a major role in the way the patient viewed death. Lobar et al (2006; 46) also found that it was the "beliefs about the soul of the deceased that lead families to perform rituals and ceremonies". According to Lobar et al (2006) it is the strength of the family's beliefs that has a direct link in their desire to perform all of the ritual ceremonies as dictated by their cultural background. An important part of these ceremonies will be prayer, which then becomes especially important to many families when a loved one is approaching death.

Toscani et al (2003) also found that a patient's view and the way they experience hope, their definition of what is a good life, their attitude towards their body and the meaning that they place on death were all affected by their own personal spiritual beliefs.

6.4 Nurses Have an Important Role

The fourth theme that emerged from the results was that nurses play an important role in ensuring that their patient receives quality end of life care. This theme is the basis of the nursing care practices of Leininger's theory.

When dealing with death, it is important to remember that at times nurses will confront patients who hold unfamiliar or conflicting views and beliefs. At these times it is important that nurses maintain a non-judgmental attitude, even though it may require a stretching of their own comfort zones.

The traditional focus of acute care nurses has been on the death of a patient rather than on the whole dying process. According to London and Lundstedt (2007; 152), during the "last decade there has been and increasing focus on the care of the dying and their families". Costello (2006) states that in order to provide a positive end of life experience attention needs to be given to ensuring that patients experience a good quality of life at the end of life. Thacker (2008) feels that nurses are in the best position to ensure these experiences as well as to support the end of life care decisions that a patient has made this, however, means that nurses need to become comfortable with not only death but the dying process.

Mcsteen et al (2006) feel that one of the key roles filled by nurses is to act as a link between health care professionals, the patient and the patient's family. By filling this role, the nurse is able to ensure that the end of life care plan is followed by all who are involved in the patient's care. Other important roles that were identified by McSteen et al (2006; 263) were "educating about the disease, teaching specific skills, and clarifying

information and options." An important result of the clarification and provision of information was that the patients were able to make best choice regarding their treatment. Costello (2006) also states that by acting as guides to help patients to sort through the confusing information and by facilitating communication, nurses were able to assist patients to prioritize their needs and wants. In acting as guides and liaisons nurses can provide families with comfort, support and reassurance. By fulfilling these roles nurses will be able to facilitate communication between all involved in the care of the patient.

In addition to acting as guides, supports and liaisons, nurses may also be called on to act as advocates on their patients' behalf. Thacker (2008; 181) feels that "advocacy is an essential component of nurses' professional role." McSteen et al (2006; 259) go on to state that the ability of the nurse to "effectively advocate for the patient can have a powerful influence on the outcome for the patient". The result of the nurse acting as a strong and effective advocate is that the patient is able to maintain self determination and dignity; as a result the patient will die in comfort and security with his or her values respected.

Mcsteen et al (2006) caution that it is important that while in the attempt to act as effective advocates, nurses do not take over decision making process but instead set aside their own views, values and beliefs in order to be better able to affirm the decisions made by patient and family. Thacker (2008) found that there is a positive link between education and the ability of the nurse to act as an advocate when caring for patients approaching the end of life. Basic supports to advocacy identified by Thacker (2008; 182) were "nurse managers, co-workers and multidisciplinary services." In addition to these basic supports Thacker (2008; 182) identified that "communication, relationship with patients, nurse beliefs, and compassion and the family" have an influence on the nurse's ability to act as an effective advocate.

6.5 There Needs to be Clear Communication

The fifth theme that emerged from the results was that, when dealing with end of life issues and care planning, there needs to be clear communication among medical staff, the patients and their families. This theme has its base in many of the cultural and social structure dimensions of Leininger's theory.

According to London and Lundtedt (2007; 157) clear communication starts when all information about the patient's prognosis is "open, honest and consistent." Thompson et al (2006, 172) found that when "patient and family had a clear understanding of the disease process and its outcome," patients and their families were better able to acknowledge that a cure was not possible and that death was the likely outcome.

When discussing end of life issues, nurses need to be sensitive to the patient's feelings and have the skills to resolve conflicts when they occur. One of the areas in which nurses need to be particularly sensitive and clear in their communication is when discussing ventilation and life support. Lobar et al (2006; 47) found that for families "there is much confusion about what to do about ventilation or life support". Daaleman et al (2006) suggest that reflecting on their own experiences of serious illness and death, as well as being in close physical proximity to patients focus wholly on the patient ensure that clear communication can be achieved.

Nurses need to be aware of the way in which they communicate with patients of different cultural backgrounds. While trained interpreters provide clear verbal communication when a common language is not found, non verbal communication can still cause misunderstandings, even when a common language is present for example, nodding their head has different meanings in different cultures. Crawley et al (2002) state that it is only when the cultural background of patients is known is it possible understand the expectations and hopes of the patient, their understanding of their illness, about care, and the manner in which they view death Thompson et al (2006) found that effective communication is essential when it comes to providing quality end of life care. Crawley et al (2002) suggest that when nurses are asking about end of life care preferences they use open ended questions that allow patients to clearly voice their preferences.

6.6 The Definition of a Good Death is Individual

The sixth theme that emerged was that the definition of what is a good death is highly individual and thus, there is no single model of a good death that can be used. This theme also draws on many of the factors that are present in the cultural and social structure dimensions of Leninger's theory. In addition this theme also touches briefly on how it is possible to combine Generic and Nursing care.

Toscani et al (2003) point out that a death can only be considered good when it matches the view that is held by the dying person, but for this to occur nurses need to understand the needs of the patient and have the tools to satisfy them. Dalian et al (2006; 408) point out that in order for nurses to understand the patients' needs they first need to be "aware of the patients' storied humanity and the individualized experience of their illness". Consideration also needs to be given to the view points that are held by the families of the patients. Family play a vital role in providing care at the end of life, and attention should be paid to their needs as well. McSteen et al (2006; 264) state that including family members "in care conferences, educating them about the expected course of the disease, providing practical instruction in how to care for their loved ones, and encouraging them to be at the bedside" are ways in which nurses can acknowledge the vital role which these families play.

Nurses need to keep in mind that all of their patients are individuals, and even though they may share a similar cultural background or religion, that will not necessarily have the same end of life needs; for example, the children of immigrants may not practice the same rituals as their parents. It is due to this difference in needs that London and Lundtedt (2007; 155) highlight the "importance of individual interactions with dying patients and their families." For some patients and their families the awareness of approaching death will not be a welcome one, while for others an awareness of death gives them a chance to prepare.

It is because of these differences London and Lundtedt (2007) state that nurses should tailor their behavior to suit the needs of the patients and their families. It is also important to keep in mind that each family member will have a unique relationship with the patient. The perspective of the family is important when it comes to assessing the quality of the end of life care that has been provided.

Costello (2006) feels that patients should given the opportunity to have a fully active role in determining the events that surround the end of life. Daaleman et al (2006; 408) agree and go on to state that patients, their family and medical staff all need to be

involved in creating a "wholistic care plan focusing on maintaining the patient's humanity and dignity in the face of death." In this way care plans maybe individualized to not only meet the cultural needs of the patient but to reflect their values as well.

When individualizing care plans, there will be times when conflicts occur, and at these time nurses need to be able to negotiate in order to be able to reach a compromise. Narayanasamy (2003; 191) suggests that developing an "integrated approach to care which incorporates orthodox and traditional cultural remedies" may be possible in some cases.

Many patients and their families will have wishes regarding specific rituals that they wish to have performed at death. Some of the factors that will influence the way in which rituals are carried out will be the patients' country of origin, the length of time they have spent in the community and their level of adaption to the new community. In this way the rituals become individualized. Lobar et al (2006; 49) state that these rituals have many purposes including "put off the death, to ward off evil, to ensure the deceased is remembered, and also for the family to achieve closure." Also included in the care plan should be the point at which the patient wishes that their family be notified of imminent death, in order that the patient can have the loved ones close when death occurs.

Regardless of the many individual aspects of a good death, some aspects are shared across all cultures and religions. It is on the bases of these fundamental aspects that high quality end of life care is built. There are also several aspects of what defines a bad death that are shared across all cultures and religions.

6.6.1 Shared Aspects of a Good Death

The death of a family member is an emotional event that forms lasting memories; for this reason it is necessary to provide quality end of life care. Quality end of life care will start with nurses having an awareness of the patients' cultural background and facilitating their role as active participants in all end of life care decision making whenever possible. The physical surroundings of a patient will also have an impact on the ability of nurses to provide quality end of life care.

Costello (2006) states that by ensuring that by ensuring that their patient's religious needs were met in addition to ensuring that the patient was made physically and psychologically comfortable, while providing comfort and alleviating concerns nurses are well on the way to providing quality end of life care. Lobar et al (2006), London and Lundtedt (2007), and Narayanasamy (2003) all highlight the importance of showing the patient and the family respect and compassion throughout the dying process. In this way the patient is able to maintain a sense of individuality and thus die with their self-respect and self-esteem intact.

Other aspects of a good death that were identified by multiple authors were: pain and symptom management, ethical decision making, open communication, acceptance of death, being present for family and patient, the opportunity to prepare for death, continuity of care, and a sense of well being. Toscani et al (2003) found that having both loved ones and nurses nearby are two important needs that are held by nearly all dying patients

6.6.2 Shared Aspects of a Undignified Death

Costello (2006) found that an undignified death was considered to have occurred when patients died with unrelieved physical symptoms such as unrelieved pain or they died while in or spiritual distress. Crawley et al (2002; 673) agrees and goes on to state that the providing of high quality end of life care can be complicated by "differences between the patient's background and traditional medical practices." These differences can lead to arguments and disagreements between medical professionals and patients about the actions that need to be taken. Narayanasamy (2003; 189) adds that "language difficulties were seen as barriers to care." Daaleman et al (2006; 409) went on to add that "lack of sufficient time was the major barrier" to the provision of care, in addition to the lack of privacy and poor communication.

6.7 Areas That Need Improvement

The final theme that emerged was that, while there have been many advances in end of life care, there are areas that still need to be improved. This theme touches on the educational and economic factors that Leininger highlights in her theory.

When providing end of life care nurses need to be aware of how their own beliefs, values and biases as well as the values and expectations of the medical professions will not only affect the way they care for patients, but whether these will be alien to the patient. Narayanasamy (2003; 194) found that there is a "need for further education in meeting cultural needs". Thompson et al (2006) add that there is also a need to increase that education and experience of nurses when it comes to dealing with end of life care.

According to Thacker (2008), fear, a lack of time, support and education are barriers to providing end of life care. Thacker (2008; 181) also finds "that physicians have difficulty in relating to end of life issues". London and Lundstedt (2007) add that while it is rare that patients experience problems with pain management or that the wishes that they have regarding their end of life care not being respected it is in these areas as well as in communication that problems are likely to occur. On busy wards it is easy for nurses to be pulled in many directions it is at these times that the quality of care that is being provided to all patients suffers.

7. DISSCUSSION

The way in which care for the dying is being provided is an increasing concern in the medical community (Thacker, 2008, London and Lundsedt, 2007, Thompson et al, 2006). This concern is set to increase as the population ages the acute care nurse will be need to be able to provide end of life care to patients from an increasingly wide range of different cultural backgrounds.

As the research for this paper has shown, each of these patients will have their own unique needs and wants when it comes to the question of end of life care. Toscani et al (2003) put it most clearly when they state that in today's society it is not possible to provide a single model of a good death. It is the role of the nurse to ensure that their patients, especially when they are approaching the end of life receive the care that they themselves feel that they need, and in this way die what is to them a good death.

It was found that nurses need to become comfortable with discussing end of life matters with their patients and their families, as Thompson et al (2006) point out it is only through experience and education can nurses become comfortable in discussing such issues. The reason why nurses need to become able to discuss end of life issues comfortably is because it is through open discussions and clear communication that comprehensive end of life care plans are developed (Crawly et al, 2002, London and Lundstedt, 2997). By having a well developed comprehensive end of life care plan, patients will also be more likely to receive better continuity of care, as all nurses are informed of the patient's wishes.

From all of the articles that met the selection criteria it was only possible to access ten articles, for this reason one of the major limitations that was faced by this study was the small sample size. An additional limitation was that there was only one author involved in the collection and analysis of the data used in this study. This leads to the possibility that some data was lost.

In the coming years acute care nurses will be increasingly called on to provide end of life care for their patients and because of this there nurses need to receive more education and experience during their training period in order to increase their comfort with dealing with end of life issues. Acute care wards can also help nurse by developing clear and comprehensive questionnaires, not unlike the health history questionnaires currently used, to guide nurses when the time comes to discuss end of life care. These end of life questionnaires can cover such things as the patient's views on the use of ventilators, to if they wish for a religious minister to be called and what they wish to be done in the moments before and after death.

8. CONCLUSION

Death is and increasingly complex and diverse issue that nurses face today and with the rapidly aging population it is a challenge that acute care nurses will face on an increasingly routine basis. The most important role of the nurse when it comes to providing end of life care is the development and implementation of comprehensive and culturally sensitive end of life care plans in partnership with patients. Once such plans are developed it the role of the nurse to ensure that they are followed. After all it is only by following the wishes patients that have been outlined in such plans can nurses help their patients to die in a dignified and peaceful manner.

9. REFERENCES

Andrews, M.M. and Hanson, P.A. (2003) Religion, Culture and Nursing. In Andrews, M.M. and Boyle, J.S. (Eds), *Transcultural Concepts in Nursing Care* 4th edition, Philadelphia: Lippincott Williams and Wilkins, 432 - 502

Alligood, M.R. (2005) Nursing Theory: The Basis for Professional Nursing. In Chitty, K.K. (Ed), *Professional Nursing Concepts and Challenges 4th edition,* Missouri: Elsevier Saunders, 271-298

Costello, John, (2006) Dying Well: Nurses' Experiences of 'Good and Bad' Deaths in Hospital, *Journal of Advanced Nursing,* 54(5) 594-601

Crawley, LaVera M, Marshall, Patricia A, Lo, Bernard and Koening, Barbra A (2002) Strategies for Culturally Effective End-Of-Life Care, *Annuals of Internal Medicine,* 136(9) 673-679

Daaleman, Timothy P, Usher, Barbara M, Williams, Sharon W, Rawlings, Jim, Hanson, Laura C, (2008) An Exploratory Study of Spiritual Care at the End of Life, *Annuals of Family Medicine,* 6(5) 406-411

Elo, Satu and Kyngäs, Helvi, (2008) The Qualitative Content Analysis Process, *Journal of Advanced Nursing,* 62(1) 107-115

Hagedorn, Mary I Enzman (2004) Caring Practices in the 21st Centuary: The Emerging Role of Nurse Practitioners, *Topics in Advanced Practice Nursing eJournal* 4(4)

Leininger, Madeleine M (2006) Culture Care Diversity and Universality Theory and Evolution of The Ethnonursing Method, in Leiniger, Madeleine M and McFarland Marilyn R (eds), *Cultural Care Diversity and Universality A Worldwide Nursing Theory* 2nd edition, Sudbury, Jones and Bartlet, 1-41

Leiniger, Madeleine M (2002) The Theory of Culture Care And The Ethnonursing Research Method, in Leiniger, Madeleine M and McFarland Marilyn R (eds), *Transcultural Nursing Concepts, Theories, Research and Practice* 3rd edition, New York, McGraw-Hill, 71-116

Lobar, Sandra L., Youngblut, JoAnne M, Brooten, Dorothy (2006) Cross-Cultural Beliefs, Ceremonies, and Rituals Surrounding Death of a Loved One, *Paediatric Nursing*, 32(1), 44-50

London, Maria R and Lundstedt, Janyce (2007) Families Speak About Inpatient End-of-Life Care, *Journal of Nursing Care Quality,* 22(2) 152-158

McFarland, Mary (2006) Culture Care Theory of Diversity and Universality, In Tomey. Ann Marriner and Alligood, Martha Raile (Eds), *Nursing Theorists and Their Work 6th edition,* Missouri: Mosby Elsevier, 472-496

McSteen, Kerstin, Peden-McAlpine, Cynthia, (2006) The Role of the Nurse as Advocate in Ethically Difficult Care Situations With Dying Patients, *Journal of Hospice and Palliative Nursing*, 8(05), 259-69

Narayanasamy, Aru, (2003) Transcultural Nursing: How do Nurses Respond to Cultural Needs?, *British Journal of Nursing,* 12(3) 185-194

Thacker, Karen S, (2008) Nurses' Advocacy Behaviours in End-of-Life Nursing Care, *Nursing Ethics,* 15(2) 174-185

Thompson, Genevieve, McClement, Susan and Daeninck, Paul, (2006) Nurses' Preceptions of Quality End-of-Life Care on an Acute Medical Ward, *Journal of Advanced Nursing,* 53(2) 169-177

Toscani, Franco, Borreani, Claudia, Boeri, Paolo and Miccinesi, Guido (2003) Life at the End of Life: Beliefs About Individual Life After Death and "Good Death" Models – a Qualitative Study, *Health and Quality of Life Outcomes,* e-journal, (1)65

APPENDIX ONE: ARTICLE SUMMARY TABLE

Author, Year	Purpose	Sample	Data Collection	Results
Crawley, et al, 2002, USA	Illustrate how cultural differences affect aspects of end of life care	2 patients	Case study	• Challenges result from cultural differences between patient background and traditional medical practices • Values and expectations unquestioned by medical staff maybe alien to patient • Need to be sensitive, and have skills to resolve conflict and clarify end of life care • Patient cultural and social background influence end of life care preferences • Quality end of life care requires attention to cultural background • Only through knowing cultural background will patient's wishes and views make sense • In some cultures treatment decisions made as family and discussions held with family members and not patient • Non verbal behaviours e.g. nodding head may have different meanings • Trained interpreters ensure effective communications when a common language is not found • Need to be aware of how culture shapes; values, beliefs and world view, acknowledge and respect differences • Need to have a non-judgemental attitude toward unfamiliar beliefs and practices • Willing to negotiate and compromise in order to provide care when view conflict • Influence of culture on meaning of death and dying affect the way symptoms managed, care plans, and grief • Feelings towards life support, withholding/withdrawing

				treatment may affected by ethnicity, sometimes however these choices are contradictory • Community and cultural ties provide comfort • Complicated by disagreements between physicians and patients, actions, interactions, decisions • Be aware of how own beliefs, view and biases affect care • Patients individuals and all members may not share same cultural traits • Use open ended questions to ensure clear communication
Costello, 2006, UK	Investigate hospital nurses' experiences of death and dying	29 nurses	Interview	• Ideology of good death has origins in hospice care • Characteristics of good death; open communication, relief of symptoms, individual dignity, respect, acceptance of death • Death is complex and diverse • Meeting religious needs, physical and psychological comfort, alleviating family concerns are part of providing a good death • Unresolved physical and psychological issues, poor communication part of bad death • Undignified death when symptoms not controlled • Need to provide quality of life and positive experiences in end of life care • Need to improve communication • Patients need a role in determining end of life care • Nurse's focus on the death event and not the dying process
Daaleman et al, 2008, USA	To explore how clinicians and health care workers understand and view spiritual care	12 clinicians and health care workers	Interviews	• Acknowledge need for spiritual care and support spiritual care are what patients and family want • Impediments of spiritual care; lack of time, social religious cultural differences, lack of privacy, lack of continuity

				• Facilitators of spiritual care, time, good communication, family experience • Being present for family and patient important • Giving attention to emotional, social and spiritual needs part of being present • Physical proximity helps with communication • Aware of patient's individual experience of illness and understanding their perspective as well as that of family and friends • Family, patient and medical staff all need to be involved in creating a care plan that maintains the patient's dignity at the end of life • Reflections on personal experiences can help to improve communication
Lobar et al, 2006, USA	Describe the practices surrounding death of a loved one from different cultural groups	Focus group of 14 nursing masters students	Qualitative study interviews	• Grieving and death rituals vary across cultures and are influenced by religion • How rituals practiced vary across individuals depending on country of origin, length of time in community and level of adaption • Manner of death also influences grief process • Beliefs about soul guide rituals • Stronger the beliefs the more motivated family is to perform rituals in way that is dictated by religion or culture • Younger generations may not practice all the rituals of older generations • The meaning/significance of some rituals lost over time, although rituals still practiced • Difficulty in separating influence of culture and religion • Who involved and how care is done of dying influenced by culture • Younger person is at death the more difficult for the family

				• Prayer important to many families • Patient and family may wish to perform some rituals to prevent death • Need to be clear when talking about ventilation and life support • Respect for the dead and family important • Way grief is expressed varies and is influenced by culture • Family and patient may have wishes regarding death rituals, these need to be followed when ever possible • Some beliefs common • Religion and culture important and nurses need to help families and patients at the end of life to complete rituals so that beliefs are respected • Rituals serve many purposes and may be part of ceremonies • Nurses need to be sensitive to needs of patient and families
London, and Lundstedt, 2007, USA		855 families	survey	• Increasing focus on the care of the dying • Death of a loved one is emotional event, leaving lasting memories • Perspective of the family important to assess the quality of end of life care • Individual interactions with patient and family important • Treating patient and family with care and compassion and respect important • Pain management and end of life care wishes areas where problems can occur • Provide ongoing honest information • Ensure that communication is clear • If patient and family wish let them know when death is imminent so they can be present • Provide good pain management • Individualize care plans

				• Pay attention to family members needs as well as patient • Continuity of care important • Tailor behaviours to the individual needs of patient and family
McSteen, 2006, USA	To identify and illustrate the key activities of expert nurses who act as patient advocates in ethically difficult situations involving dying patients	Unstructured narrative interview of 7 nurses	Qualitative study	• Ethical and moral issues may surround dying • The effective advocacy of the nurse may influence the outcome of the patient's care • Nurse act as guide, supporter and liaison for patient and family • Nurses clarify information about treatment and options, by doing so they facilitate communication • Help to prioritize needs and wants • Advocates do not take over decision making • Being advocate so patient maintain self determination high value • Families play an crucial role in caring for patients at the end of life and need to be educated about prognosis • Nurses act as link between health care professionals to ensure all parties (medical and family) understand and follow care plan • Each family member has individual relationship with patient • Advocates set aside own views, values and beliefs to affirm the decisions made by patient and family • Nurse provide comfort, reassurance and support to family • Nurse may need to stretch comfort zone • Nurses provide information so patients can make best choice for self • Strong advocacy patient dies in comfort and security, dignity intact, values respected
Narayanasa, 2003, England	Explore how nurses respond to the cultural needs of clients	126 nurses	Questionnaire	• Religious and dietary needs most commonly recognised cultural needs

				• Lack of common language is a barrier to care • Cultural care seen as synonymous with religious care • Cultural care includes; religious needs, diet needs, communication needs, and dying needs • Cultural needs cover many things • Cultural and religious needs integral to overall wellbeing • Patients may share religion but have different cultural needs • Awareness of different cultures needed • Cultural compromise; orthodox and traditional care practices at the same time • Develop care plans with patient to ensure culturally sensitive care • Respect patient individuality to maintain the self-respect and self esteem • Different cultures different needs re non verbal communication and personal space and intimacy • More education is needed to ensure cultural competence
Thacker, 2008, USA	Reveal acute care nurses' perceptions of advocacy behaviours in end of life nursing	333 nurses	survey	• Advocacy and end of life care has changed drastically • Quality end of life care; pain management, symptom management, ethical decision making, competent culturally sensitive care, and caring for people through death • Nurses are key positions to support end of life care decisions • Disparity between the way people die and the way they want to die increasing • Education positively influence advocacy in end of life care • Advocacy essential component of nurse's professional role • Physicians have difficulty relating to end of life issues • Fear barrier to advocacy in end of life care • Acute care nurses care for dying patients on a routine basis • Identified supports to advocacy; nurse managers, co-workers and

				multidisciplinary services • Communication, relationship with patients, nurse beliefs, compassion and family support advocacy • Barriers to advocacy; physician, family, lack of communication, lack of time, lack of support, and personal fear • Demand for end of life care continue as elderly population grows
Tompson et al, 2006, Canada	Report on the nursing behaviours and social processes needed to provide quality end of life care	10 Nurses	Interview	• Providing quality end of life care has become a major concern • Problem experienced by nurses providing end of life care while being pulled in all directions • Recognition and acknowledgement by all that death is approaching • Patient and family clear understanding of disease process • Patient active participant in decision making • Care plans reflect values and needs of patients • Lack of education and experience in care of dying are barriers to quality end of life care • Being present and providing emotional support to family • Nurses' need to be comfortable with death and dying • Family acknowledgement that a cure is not possible and death will be the outcome • Nurses need to be open and honest in communication with family • Effective communication essential in providing end of life care

Toscani, 2003, Italy	Identify the influence of believing in individual life after death on "good death" models	8 people; 4 believers and 4 non-believers	Semi-structured interview	• Death is good when it fits the role given, acknowledged, and accepted by patient • In past acceptance of death easier, dying person placed in a socially shared scenario where meaning was found • Death involves a wide set of rites, shared behaviour and socially significant acts • A belief or non belief in an after life affects view and experience of death • For some an awareness of death is not welcome • The way hope is seen and experienced is different between believers and non believers • Definition of a good life is different between believers and non believers • The scene of death leaves a lasting memory • Attitudes towards body is different between believers and non believers • The meaning of death is different between believers and non believers • Believers and non believers agree on that having a possibility to prepare for death, however it is never possible to be fully prepared • An important need of the dying is to have the nearness of loved ones and experts in end of life care • Understanding and satisfaction of patient needs important • Patients need to see nurses accept death as being natural • Good death aspects; symptom control, relationships, preparations, sense of well being • There is no single model of a good death

APPENDIX TWO: ANALYSIS CHART

Article Points	Themes
• Death is complex and diverse • Manner of death also influences grief process • Younger person is at death the more difficult for the family • Community and cultural ties provide comfort • The meaning/significance of some rituals lost over time, although rituals still practiced • Ethical and moral issues may surround dying • Demand for end of life care continue as elderly population • Acute care nurses care for dying patients for dying patients on a routine basis • Ideology of good death has origins in hospice care • Disparity between the way people die and the way they want to die increasing • Advocacy and end of life care has changed drastically • Providing quality end of life care has become a major concern • The scene of death leaves a lasting memory • Death involves a wide set of rites, shared behavior and socially significant acts • Patients need to see nurses accept death as being natural • In past acceptance of death easier, dying person placed in a socially shared scenario where meaning was found	Death is a Complex Issue
• Acknowledge need for spiritual care and support are what patients and family want • Giving attention to emotional, social and spiritual needs part of being present • Beliefs about soul guide rituals • Prayer important to many families • Stronger the beliefs the more motivated family is to perform rituals in way that is dictated by religion or culture • A belief or non belief in an after life affects view and experience of death • Attitudes towards body is different between believers and non believers • The meaning of death is different between believers and non believers • The way hope is seen and experienced is different between believers and non believers • Definition of a good life is different between believers and non believers	A person's beliefs affect their view of death

- Need to have an non-judgmental attitude toward unfamiliar beliefs and practices
- Nurse's focus on the death event and not the dying process
- Need to provide quality of life and positive experiences in end of life care
- Increasing focus on the care of the dying
- Nurses act as link between health care professionals to ensure all parties(medical and family) understand and follow care plan
- Nurses clarify information about treatment and options, by doing so they facilitate communication
- Help to prioritize needs and wants
- Being advocate so patient maintain self determination high value
- Strong advocacy patient dies in comfort and security, dignity intact, values respected
- The effective advocacy of the nurse may influence the outcome of the patient's care
- Nurse act as guide, supporter and liaison for patient and family
- Advocate set aside own views, values and beliefs to affirm the decisions made by patient and family
- Nurses may need to stretch comfort zone
- Nurse provide comfort, reassurance and support to family
- Nurses provide information so patients can make best choice for self
- Advocates do not take over decision making
- Advocacy essential component of nurse's professional role
- Identified supports to advocacy; nurse managers, co-workers and multidisciplinary services
- Communication, relationship with patients, nurse beliefs, compassion and family support advocacy
- Nurses are key positions to support end of life care decisions
- Being present and providing emotional support to family
- Nurses' need to be comfortable with death and dying
- Education positively influences advocacy in end of life care

Nurses have an important role in end of life care

- Complicated by disagreements between physicians and patients, actions, interactions, decisions
- Unresolved physical and psychological issues, poor communication part of bad death
- Undignified death when symptoms not controlled
- Impediments of spiritual care; lack of time, social religious cultural differences, lack of privacy, lack of continuity
- Challenges result from cultural differences between patient background and traditional medical practices

Aspects of a bad death

- Use open ended questions to ensure clear communication
- Trained interpreters ensure effective communications when a common language is not found
- Only thorough knowing patient's cultural background will wishes and views make sense
- Non verbal behaviors e.g. nodding head may have different meanings
- Need to be sensitive, and have skills to resolve conflict and clarify end of life care
- Reflections on personal experiences can help to improve communication
- Physical proximity helps with communication
- Need to be clear when talking about ventilation and life support
- Ensure that communication is clear
- Provide ongoing honest information
- Patient and family clear understanding of disease process
- Effective communication essential in providing end of life care
- Nurses need to be open and honest in communication with family
- Recognition and acknowledgement by all that death is approaching
- Family acknowledgement that a cure is not possible and death will be the outcome

Clear communication is important

- In some cultures treatment decisions made as family and discussions held with family members
- Feelings towards life support, withholding/withdrawing treatment may be affected by ethnicity, sometimes however these choices are contradictory
- Patient cultural and social background influence end of life care preferences
- Need to be aware of how culture shapes; values, beliefs and world view, acknowledge and respect differences
- Grieving and death rituals vary across cultures and are influenced by religion
- Way grief is expressed varies and is influenced by culture
- Difficultly in separating influence of culture and religion
- Religion and culture important and nurses need to help families and patients at the end of life to complete rituals so that beliefs are respected
- Rituals serve many purposes and may be part of ceremonies
- Who involved and how care is done of dying influenced by culture
- Cultural care seen as synonymous with religious care
- Different cultures different needs re non verbal communication and personal space and intimacy
- Cultural needs cover many things
- Religious and dietary needs most commonly recognized cultural needs
- Cultural and religious needs integral to overall wellbeing
- Cultural care includes; religious needs, diet needs , communication needs and dying needs
- Influence of culture on meaning of death and dying affect the way symptoms managed, care plans and grief

Culture plays a part in determining a good death

- Quality end of life care requires attentions to cultural background
- Meeting religious needs, physical and psychological comfort, alleviating family concerns are part of providing a good death
- Characteristics of good death; open communication, relief of symptoms, individual dignity, respect, acceptance of death
- Facilitators of spiritual care, time, good communication, family experience
- Being present for family and patient important
- Some beliefs common
- Respect for the dead and family important
- Treating patient and family with care and compassion and respect important
- Provide good pain management
- Continuity of care important
- Death of a loved one is emotional event, leaving lasting memories
- Respect patient individuality to maintain the self-respect and self esteem
- Patient active participant in decision making
- Good death aspects; symptom control, relationships, preparations, sense of well being
- Believers and non believers agree on that having a possibility to prepare for death, however it is never possible to be fully prepared
- An important need of the dying is to have the nearness of loved ones and experts in end of life care Quality end of life care; pain and symptom management, ethical decision making, competent culturally sensitive care, and caring for people through death

Aspects of a good death

- Be aware of how own beliefs, views and biases affect care
- Values and expectations unquestioned by medical staff maybe alien to patient
- Need to improve communication
- Pain management and end of life care wishes areas where problems can occur
- Awareness of different cultures needed
- Lack of common language is a barrier to care
- More education is needed to ensure cultural competence
- Physicians have difficulty relating to end of life issues
- Fear barrier to advocacy in end of life care
- Barriers to advocacy; physician, family, lack of communication, lack of time, lack of support, and personal fear
- Problem experienced by nurses providing end of life care while being pulled in all directions
- Lack of education and experience in care of dying are barriers to quality end of life care

Areas that need improvement

- Willing to negotiate and compromise in order to provide care when views conflict
- Patients individuals and all members may not share same cultural traits
- Patients need a role in determining end of life care
- Family patient and medical staff all need to be involved in creating a care plan that maintains the patient's dignity at the end of life
- Aware of patient's individual experience of illness and understanding their perspective as well as that of family and friends
- How rituals practiced vary across individuals depending on country of origin, length of time in community and level of adaption
- Family and patient may have wishes regarding death rituals, these need to be followed when ever possible
- Patient and family may wish to perform some rituals to prevent death
- Younger generation may not practice all the rituals of older generations
- Tailor behaviors to the individual needs of the patient and family
- Individual interactions with patient and family important
- Individualize care plans
- Perspective of the family to assess the quality of end of life care
- If patent and family wish let them know when death is imminent so they can be present
- Each family member has individual relationship with patient
- Families play an crucial role in caring for patients at the end of life and need to be educated about prognosis
- Develop care plans with patient to ensure culturally sensitive care
- Cultural compromise; orthodox and traditional care practices at the same time
- Patients may share religion but have different cultural needs
- Care plans values and needs of patients
- Death is good when it fits the role given, acknowledged, and accepted by patient
- For some and awareness of death is not welcome
- Pay attention to the family members needs as well as patient
- Understanding and satisfaction of patient needs important
- Nurses need to be sensitive to needs of patient and families
- There is no single model of a good death

A Good death is individual