UNIVERSITY OF CAPE COAST

ASSESSING THE PRACTICES OF PALLIATIVE AND END-OF-LIFE CARE AMONG NURSES: A STUDY AT CAPE COAST TEACHING HOSPITAL

ABIGAIL BOATEMAA OWUSU

2019

UNIVERSITY OF CAPE COAST

ASSESSING THE PRACTICES OF PALLIATIVE AND END-OF- LIFE CARE AMONG NURSES AT CAPE COAST TEACHING HOSPITAL

BY

ABIGAIL BOATEMAA OWUSU

Thesis submitted to the Department of Nursing and Midwifery, College of Health and Allied Sciences, in partial fulfilment of the requirements for the award of Master of Nursing

MARCH 2019

DECLARATION

Candidate's Declaration

I hereby declare that this thesis is the result of my own original research and that no part of it has been presented for another degree in University of Cape Coast.

Candidate's Signature ………………..…….……   Date………..……………

Name: Abigail Boatemaa Owusu

Supervisors' Declaration

We hereby declare that the preparation and presentation of this thesis was supervised in accordance with the guidelines on supervision of thesis laid down by the University of Cape Coast.

Principal Supervisor's Signature……..................... Date…………………

Name: Dr. Jacob Setorglo

Co-Supervisor's Signature……............................... Date…………………

Name: Dr. Michael Tetteh Anim

ABSTRACT

In the past decade, the number of people living with life-threatening diseases has increased. However, these people need to live their remaining lifetime as meaningful as possible, even when they are at the end stage and may have few months to live. This study therefore sought to examine the practices of palliative care (PC) and end-of-life care among nurses at Cape Coast Teaching Hospital (CCTH). The study employed analytical cross-sectional design. The instrument used for the study was a questionnaire and 215 respondents were randomly selected. Frequency counts and percentages, means and standard deviations, one sample t-test as well as Pearson product moment correlation coefficient (r) was employed in the analysis. The results of the study showed that the nurses at CCTH have a good knowledge in palliative care (M=17.4, SD = 0.91). They also have a favourable attitude towards palliative care. Again, the study found that nurses at CCTH to a great extent practice palliative care. The study also revealed a statistically significant, low positive correlation ($r = 0.146, p = 0.041$) between nurses' knowledge and practice; and between knowledge and attitude ($r = 0.313, p < 0.001$). More so, nurses perceived poor funding and inadequate education as the key barriers to palliative care practices at the CCTH. The study therefore, recommends that authorities at CCTH should focus on continuous in-service training as well as encouraging nurses to continually sustain favourable attitude towards the terminally ill and dying patients. More so, management should place much emphasis on the establishment of PC specialty unit in the hospital to provide holistic end-of-life healthcare to terminally ill patient who requires PC services.

KEYWORDS

Cape Coast Teaching Hospital

End-of-Life care

Knowledge

Nurses

Palliative Care

Practices

ACKNOWLEDGEMENTS

I am very grateful to my supervisors: Dr. Jacob Setorglo of Department of Medical Biochemistry and Dr. Michael Tetteh Anim of Department of Psychological Medicine and Mental Health, for their meticulous feedback, critiques, encouragements and contributions in making this work a success.

My sincere appreciation goes to Research Department of Cape Coast Teaching Hospital for giving me access to the facility. I am also grateful to Mr. Abraham Yeboah of Department of Education and Psychology for his expert guidance on data analysis and interpretation.

I also extend my warmest gratitude to my family, especially my brother Dr. Samuel Kwaku Agyei and husband Mr. Absalom Odoom for their prayers and support for making this work a reality.

DEDICATION

To my Family

TABLE OF CONTENTS

Page

CHAPTER ONE: INTRODUCTION

CHAPTER TWO: LITERATURE REVIEW

CHAPTER THREE: RESEARCH METHODS

LIST OF TABLES

LIST OF FIGURES

LIST OF ACRONYMS

AIDS	Acquired Immuno-Deficiency Syndrome
CDC	Centre for Disease Control and Prevention
CCTH	Cape Coast Teaching Hospital
ER	Emergency Room
FATCOD	Frommelt Attitude toward Care of the Dying Scale
HIV	Human Immune Virus
ICU	Intensive Care Unit
IRB	Institutional Review Board
NCDs	Non-Communicable Diseases
NGOs	Non-Governmental Organisations
OPD	Out-Patient Department
PC	Palliative Care
PCQN	Palliative Care Quiz for Nurses
UCC	University of Cape Coast
UNAIDS	United Nations Program on AIDS
US	United States
WHO	World Health Organisation

CHAPTER ONE

INTRODUCTION

Background to the Study

Palliative care is an essential care needed in nursing practice when it comes to caring for the terminally ill or dying patient. Death is a phenomenon that is unavoidable and affects every human being, a fact that cannot be eluded by humans. This truth leads to anxiety that is noticeable with patients and their family members when diagnosis uncovers incurable disease. In the past decade, the number of people living with life-threatening diseases have increased (Iranmanesh, Razban, Tirgari, & Zahra, 2014). According to Iranmanesh et al., these people need to live their remaining lifetime as meaningful as possible, even when they are at the end stage and may have few months to live

Nurses are always present and play a key role in caring for dying patients at both the beginning of life and the end-of-life, and this role is being noted as one of the most stressful aspects of nursing (Hopkinson, Hallett, & Luker, 2005). Most often than not, nurses find it challenging and emotionally burdened to deliver palliative care to patients (Ayed, Sayej, Harazneh, Fashafsheh, & Eqtait, 2015). They act as an advocate, liaison, and translator between physician and patient or family members for the decision-making process (Hopkinson et al., 2005). Nurses mostly rely on their relationship with each patient in order to be successful in palliative care and nurses' interest and readiness to care for people at the end of life accounts for their success in palliative care (Olthuis, Dekkers, & Leget, 2006).

Palliative care (PC) is an evolving area in medicine and its purpose is to improve the quality of life of patients with chronic diseases such as cancer, end stage renal failure, chronic obstructive pulmonary disease and many more (Das & Haseena, 2015). Sorifa and Mosphea (2015) pointed out that, palliative medicine has become an essential part of cancer care in the past 30 years which has led to the initiation of hospice type of care. Sorifa & Mosphea indicated that the first hospital-based palliative care programme began in United States in the late 1980s.

According to the World Health Organization [WHO] (2009), PC is seen as the active total care of a patient whose disease is not responsive to curative treatment. World Health Organization defines PC as an approach that improves the quality of life of patients and their families facing the problems associated with life threatening illness, through prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems like physical, psychosocial and spiritual (Joseph, Jayarama, & Kotian, 2009).

Palliative Care is a philosophy of care that provides a combination of disease modifying and supportive, compassionate therapies intended to alleviate pain and other symptoms while addressing the emotional, social, cultural, and spiritual needs of patients and families who are experiencing life threatening progressive illness (Das & Haseena, 2015). The Provision of PC focuses on symptoms such as pain, shortness of breath, fatigue, constipation, nausea, loss of appetite, difficulty of sleeping and depression. It also helps critically ill patients to gain strength for improving their ability to tolerate medical treatment (Basal & Younis, 2017). PC is the active total care of patients in advanced and at incurable stages of debilitating conditions such as cancer.

Palliative practice in the present day highlights the continuum of care, which includes disease-modifying treatment, palliative care, hospice care, and bereavement. In a nut shell, end-of-life care extends from the beginning of the disease curative process and lasts through therapeutic treatment (Hallenbeck, 2003; Kuebler, Heidrich, & Esper, 2007).

Palliative Care is rarely mentioned at the bedside unless malignant, metastatic, inoperable cancer is the diagnosis. It is an alternative for individuals and families who want a better quality of life despite their terminal illness diagnosis, especially for patients who are tired of all the medications and invasive procedures specified for their care and wish to be cared for at home, PC becomes a comfortable and safe alternative (Ghoche, 2012).

Centres for Disease Control and Prevention [CDC] (2013) indicates that with the aging population and increase in means to continue life, individuals are living longer lives with a mean life expectancy of 78.7 years (as cited in Pope, 2013). The World Health Organization (WHO) estimates that non-communicable diseases (NCDs) will be the main cause of high morbidity and mortality among the world population by 2020 (Das & Haseena, 2015). It is a foremost commission for health systems worldwide to deliver appropriate palliative care.

Countries such as Japan, Hong Kong, Italy and Australia have experienced dramatic improvements in population life expectancy which can be ascribed to competent and compassionate end-of-life care (Das & Haseena, 2015). All treatments for chronic and incurable illnesses such as HIV are palliative, and the simultaneous and interwoven use of disease-modifying and palliative treatments constitute the best possible care (Singer & Bowman, 2002).

Singer and Bowman further elaborates that within each society, and on a global scale, health care providers must strive to assure access to this kind of comprehensive care for all people living with HIV/AIDS and other serious illnesses.

Most of the patients diagnosed with terminal illness and are nearing death, generally benefit from PC which results in prolonged life. According to Sorifa & Mosphea (2015), more than 70% of all cancer patients in India require palliative care for relief of pain, other symptoms and psychosocial distress. With PC, life is prolonged when it is deemed futile particularly with regards to chronic disease processes. The results of a study in The New England Journal of Medicine in 2010 revealed that lung cancer patients under palliative care are exposed to low depression, improved quality of life and enjoyed more months than their counterpart on standard oncologic care (Das & Haseena, 2015). Das & Haseena indicated in their study conducted in Malappuram District of Kerala, that around 40% of people who are dying would have benefited if principles of palliative care had been applied in managing diseases.

To provide quality care on PC, nurses must not only possess knowledge and skills but must also develop positive attitudes towards the dying patient. The transition from curative to comfort care requires excellent clinical and communication skills from all caregivers (Basal & Younis, 2017). The value of PC to nurses who deliver majority of care to critically ill patients is unquestionable, and there is a need to support and educate nurses for the provision of high-quality palliative and end-of-life care. The need for education and training in PC is also emphasized by the World Health Organization (Sorifa & Mosphea, 2015). Nevertheless, research has indicated that the education of health professionals in end-of-life care has been limited or non-existent in nursing and in medicine (Skår, 2010).

A study in 2009 regarding palliative care in 120 US cancer centers reported that only 23% of the centres had beds that are dedicated to palliative care. Thirty-Seven percent offered inpatient hospice care and 75% had a median time of referral to palliative care to the time of death of 30-120 days. Research programs and palliative care fellowships are uncommon (as cited in Das & Haseena, 2015). Karkada, Nayak, and Malathi (2011), have also noted that nurses make up a large part of the healthcare profession, yet they are falling behind on instituting palliative care within the education curriculum.

The consequences of lack of formal education, and knowledge deficiencies in palliative care can significantly translate into poor quality service among nurses as identified in a study conducted by Sarfo, Opare, Awuah-Peasah, and Asamoah (2016). Nurses are the caregivers who provide the most direct care and spend most time with patients and their families, hence, it is essential for them to feel empowered and have necessary education and support to provide optimal end-of-life care (Basal & Younis, 2017).

Statement of the Problem

In various hospitals in the world all over, and especially, in Africa and for that matter Ghanaian hospitals, the need for the provision of palliative care is greater due to the high burden of diseases (WHO, 2010; United Nations programs on AIDS [UNAIDS], 2010). Each year, an estimated 40 million people are in need of palliative care, 78% of them live in low-and middle-income countries (WHO, 2010). In spite of the relevance of palliative care, studies on palliative care have not paid much attention to the knowledge, attitudes and practices of palliative and end-of-life care among Ghanaian nurses (Ajayi et al., 2014).

A study conducted by Ayed et al. (2015) in Palestine revealed that nurses had poor knowledge and moderate attitude towards Palliative Care. Again, in Greece, a research conducted by Kalogeropoulou and Evanthia (2016) also unravelled that there is lack of proper training and there are very few healthcare units specializing in Palliative care provision in Greece. Also, in India a study by Karkada et al. (2011), have uncovered that nurses make up a large part of the healthcare profession, yet they are falling behind on instituting palliative care within the education curriculum. All the above-mentioned studies were conducted in a different socio-cultural contexts and locations outside Africa, and for that matter, outside of Ghana.

On the African continent, the work of Bassal and Younis (2017) in Egypt, reveals that palliative care knowledge and end-of-life care is considered low among nurses at Tanta University Hospital. Again, a cross-sectional quantitative study by Kassa et al. (2014) in Ethiopia affirms that palliative care and the nature of palliative services offered are concepts that are new and less known among Ethiopian nurses. None of these studies however explored the knowledge, attitudes and practices of nurses in Ghana, not to mention Cape Coast Teaching Hospital.

In the Ghanaian context, literature on the knowledge of healthcare professionals is hard to come by, talk less of the Cape Coast Teaching Hospital. However, the scanty of literature available portrays that the consequences of lack of formal education, and knowledge deficiencies in palliative care had significantly translated into poor quality service among nurses as identified in a study conducted by Sarfo, Opare, Awuah-Peasah, and Asamoah (2016) at Agogo Presbyterian Hospital in the Ashanti region of Ghana.

According to Basal & Younis (2017), to provide quality care on PC, nurses must not only possess knowledge and skills but must also develop positive attitudes towards the dying patient. The transition from curative to comfort care requires excellent clinical and communication skills from all caregivers. Therefore, attitudes of nurses are very crucial point in dealing with Palliative Care for the quality of healthcare service provision in the Ghanaian hospitals.

The above discussion gives much evidence to suggest that very little or nothing much is known about the knowledge, attitudes and practices of palliative and end-of-life care among nurses at the CCTH. In order to understand and appreciate the complexity of PC practices among nurses in our setting, and the effect of PC knowledge on nurses' attitude and practice concerning terminally ill patients, a study must be conducted to reveal the knowledge level, attitude and practice of PC among nurses in Ghana. The study would contribute to PC in Africa and in the world at large. Hence the urge to embark on this study.

Objectives of the Study

The main objective of the study was to examine the knowledge, attitude and practice of palliative and end-of-life care among nurses at Cape Coast Teaching Hospital. The specific objectives of the study were to;

1. Determine the knowledge level, attitude and practice of palliative care among nurses at CCTH.

2. Examine the influence of respondents' age, qualification and working experience on the practices of PC at CCTH.
3. Ascertain the relationship between knowledge and practice and between knowledge and attitude of PC among nurses at CCTH.
4. Determine what nurses at CCTH perceive to be barriers to PC practices.

Research Questions

The study was guided by the following research questions:

1. What is the knowledge level, attitude and practice of PC among nurses at CCTH?
2. What is the influence of respondent's age, qualification and working experience on the practices of PC at CCTH?
3. What is the relationship between knowledge level and PC practice and between knowledge level and attitude among nurses at CCTH?
4. What do nurses at CCTH perceive as barriers to PC practices?

Significance of the Study

The findings of the study are expected to benefit many identified stakeholders including subscribers of the Healthcare Institutions, Ministry of Health (MOH), Patients and Nurses and Academic Literature. The findings of this research will also help the numerous stakeholders to make reliable decisions as well as take actions in establishing palliative care specialist unit (Hospice) to care for the terminally ill and dying patients.

More so, the findings would help the nursing administration to develop strategies to support and educate nurses either formally or informally to provide high quality palliative and end-of-life care at the hospital. Lastly, the result will also contribute to the public dialogue and academic understanding of palliative care.

Delimitation of Study

The goal of palliative care is not to cure but to provide comfort and highest possible quality of life as long as life remains (Kuebler, Heidrich, & Esper, 2007). The research was carried out to assess the knowledge, attitude and practice of PC among nurses, particularly, the case of Cape Coast Teaching Hospital (CCTH) in the Central Region of Ghana.

The study was confined to the Cape Coast Teaching Hospital in the Central region of Ghana. The region has several hospitals which could have been used for the study. CCTH has specialised doctors and nurses in many fields of medicine and provides health care services to wider range of patients including terminally ill and dying patients (CCTH, 2016). The study was also centered on registered and enrolled nurses amidst other health professionals such as Doctors, Pharmacists, Clinical health psychologist and other paramedics at CCTH. The study focused on registered and enrolled nurses who had worked at CCTH for at least six months before the study. Cross-sectional analytic design was used to survey the respondents through administration of questionnaire. 215 respondents were surveyed. Nevertheless, the study did not focus on gender difference interest in PC practices and patient satisfaction with PC at the hospital.

Limitations

Every study is subject to certain intrinsic limitations. The magnitude of limitation associated with a particular study may influence the validity and/or reliability of the study. The major limitation of the study was the unenthusiastic attitude of nurses toward research work and especially completion of questionnaires, despite the effort made to encourage respondents to contribute to academic work. This resulted in 215 (93.5%) out of 230 of the questionnaires been recovered for data analysis. This implies that the study could not satisfy the minimum required sample size (230) though the difference was minimal (6.5%). This means that the interpretation of the findings should be done with caution (Arfken & Balon, 2011). Hence, the findings could not be generalised to the entire population. More so, by using descriptive cross-sectional design for this study, there is no attempts to offer any causal linkages. The results only reflect associations and these should be borne in mind in interpreting the results.

Definition of Terms

Some of the terms used in the study are defined below in the context as used in the study;

Nurse: A person trained to care for the sick or infirm, especially in a hospital specifically registered and enrolled nurses.

Palliative care: Care rendered to terminally ill or dying patient.

End-of-life care: Health care, not only of a person in the final hours or days of their lives, but more general care of all those with a terminal condition that has become advanced, progressive, and incurable.

Knowledge: Is an awareness, or understanding.

Attitude: A set of emotions, beliefs and behaviour toward a particular object (person, event or dying patient).

Practice: The actual application of an idea.

Organization of the Study

This research encompasses five (5) main chapters and each chapter focused on a particular aspect of the research document. Chapter One comprised of the introduction of the study, which covers the background of the study, statement of the problem, purpose of the study, research objectives and research questions, significance of the study, delimitations, and limitations as stated above.

Chapter Two handled the review of theoretical framework, conceptual framework and related literature. The chapter re-examined the theories, models, write-ups, and existing literature pertinent to the topic. The Chapter Three covered the research methodology. It principally handled the research design, the study area, the population, sampling procedure, data collection instruments and procedure, and data processing and analysis.

Under Chapter Four, data collected was analysed using both descriptive and inferential statistics with the help of Statistical Package for Social Science (SPSS version 23). An in-depth discussion of the research findings from the analysed data is also presented. In Chapter Five the summary of key findings, conclusions drawn based on the specific research objective as well as recommendations of the study was presented.

CHAPTER TWO

LITERATURE REVIEW

Introduction

The chapter aims at presenting a holistic review of pertinent theoretical framework, conceptual framework and empirical literature. The theoretical framework considers Kolcabas' Theory of Comfort from which conceptual framework are deduced. The empirical review concentrates on relevant literature relating to knowledge level of nurses, attitude of nurses, palliative practices, barriers to palliative practices and strategies necessary to prevent these barriers affecting palliative and end of life care.

Theoretical Framework

According to Grant and Osanloo (2014), a theoretical framework is perceived as the "blueprint" for the whole research work. It serves as a road map to a study; also provides a framework to define how a researcher approaches the philosophical, epistemological, methodological, and analytical aspect of a particular study. Theoretical framework is deduced from an existing theory or theories in literature which validity is tested by other researchers, and is considered as a generally acceptable theory in the scholarly literature (Grant & Osanloo, 2014). A research plan that contains a theoretical framework strengthens the research work and enhances directional flow of chapter to chapter.

Kolcaba's Theory of Comfort served as the theoretical framework for this study. This framework is applicable to this area of nursing because patient comfort is mentioned as a goal in its standards of care and is an established value for many nurses (Kolcaba & Wilson, 2002). Katherine Kolcaba explains that health seeking-behaviours are also arrayed to peaceful death; this can be linked to palliative and end-of-life care.

According to Kolcaba, Tilton, and Drouin (2006), the preliminary focal point of Comfort Theory was on patients and/or their family. This was supported by Peterson and Bredow (2009) who asserted that between 1970 and 1980 the focus of Comfort was on patients who were experiencing terminal illness or those whose medical treatment options were no longer working or available.

Comfort Theory, however, was not having an explicit definition due to certain challenges. A critical analysis by Kolcaba later illuminated the theories emphasizes on nurses (Kolcaba et al., 2006). The analysis of Kolcaba revealed three types of comfort which includes relief, ease and transcendence (Kolcaba, 2003). It can be inferred that Comfort Theory emphasizes elevating the comfort of nurses as well as patients and their families. Kolcaba et al., (2006) elaborated that, nurses' exhibit behaviour of higher satisfaction, commitment and ability to work more efficiently for an institution when their comfort is uplifted. Obviously, the outcome of nurses' satisfaction, commitment and ability to work efficiently for an institution is provision of quality health care.

Comfort Theory is a nursing theory developed in 1990s by Katharine Kolcaba (Kolcaba et al., 2006). Kolcaba has defined comfort as the instant experience of becoming strengthened by having the needs of comfort (that is relief, ease, and transcendence) which is meted in four contexts of an individual's physical, psycho-spiritual, environmental, and social (Kolcaba, 2003; Kolcaba et al., 2006).

Relief refers to situation where a particular comfort needs are accomplished. It considers controlling global factors that have potency of discomfort in order to achieve satisfaction of a need that brings immediate state of calmness or contentment. Relief emphasizes holistic result, which can quickly change with dynamic circumstances (Lima, Guedes, Silva, Freitas & Fialho, 2016).

Ease refers to calmness or contenting situations. According to Lima et al. (2016), Ease as Comfort has long lasting and continuity of contentment and well-being. Availability of comfortable environment and patient education can subdue patients' anxiety to achieve ease.

Transcendence is a situation of living beyond problems or pains. Researchers discern transcendence as a state that individuals live beyond problems or pain. It is regarded as apex of comfort emanating from education and motivation that energizes users to develop their potential and adopt health-seeking behaviours that enhance maximization of daily endeavours (Lima et al., 2016).

Kolcaba's Comfort Theory was developed to help put comfort in the forefront of healthcare. In this sense, knowing the experiences of comfort and discomfort of patients are relevant aspects for the practice of care, and guiding the care provided for the patients' needs and maximising the effect of comfort interventions (Coelho, Parola, Escobar-bravo & Apóstolo, 2016). Comfort Theory suggests that patients and their families fully seek internal health behaviours and external health behaviours when they are comfortable (Kolcaba et al., 2006).

Palliative care is comprehensive care for patients whose disease fails to respond to cure. Care also extends to families and also the management of psychosocial, social and spiritual problems in addition to control of pain and other physical symptoms (Smeltzer, Bare, Hinkle & Cheever, 2010). National Council for Palliative Care [NCfPC] (2002) argued that comfort care is a crucial component of medical care at terminal stage of life; it either assists or sooths a dying patient.

Comfort care primarily aims at preventing or relieving suffering to its barest minimum while taking into consideration the wishes of dying patient (Norlander, 2008). End of life palliative care is experienced throughout the realm of the healthcare field. Through the use of Kolcaba's Theory of Comfort, the vitality of an interdisciplinary approach towards providing patient-centred and holistic palliative care are addressed (Coelho et al., 2016).

Nurses adapt diverse interventions to mitigate physiological problems in order to increase comfort of patients. Kolcaba (2003) classified comfort interventions into standard comfort interventions to maintain homeostasis and control pain; coaching to alleviate anxiety, providing reassurance and information, instilling hope, listening, and helping plan for recovery; and comfort food for the soul, those extra nice things that nurses do to make children family feel cared for.

Characteristics of Comfort

The following explains the characteristics of comfort as described by Kolcaba, and they are expressed in four taxonomic structure. Nurses assess the holistic comfort needs of patients in all settings, thus they are addressed by means of the four contexts (Taxonomic Structure of Comfort):

1. **Physical**- pertaining to sensations (pain, cold, heat, tingling), homeostatic mechanisms (temperature control, bleeding, vomiting- can all disrupt this area) or function of the immune system. Nurses consciously undertake assessment that covers the four contexts of comfort. The physical assessment needs focus on identifying gaps existing in the physiological mechanisms of an ill patient whose illness is resulting from a disease, virus or surgery. Some physical needs can be treated without medications and these may include nausea, vomiting, pain, and itching and shivering.
2. **Psych spiritual-** pertaining to internal awareness of self, including esteem, identity, sexuality, meaning in one's life, and one's feelings or belief in a higher power or superior being.
3. **Environmental-** referring to the external background of human experience (temperature, light, sound, odour, colour, furniture, landscape).
4. **Socio-cultural-** pertaining to interpersonal, family and societal relationships; also includes family traditions, rituals and religious practices (Kolcaba et al., 2006). The figure below demonstrates the theoretical framework on palliative care as adopted from Katherine Kolcaba (2003) comfort theory.

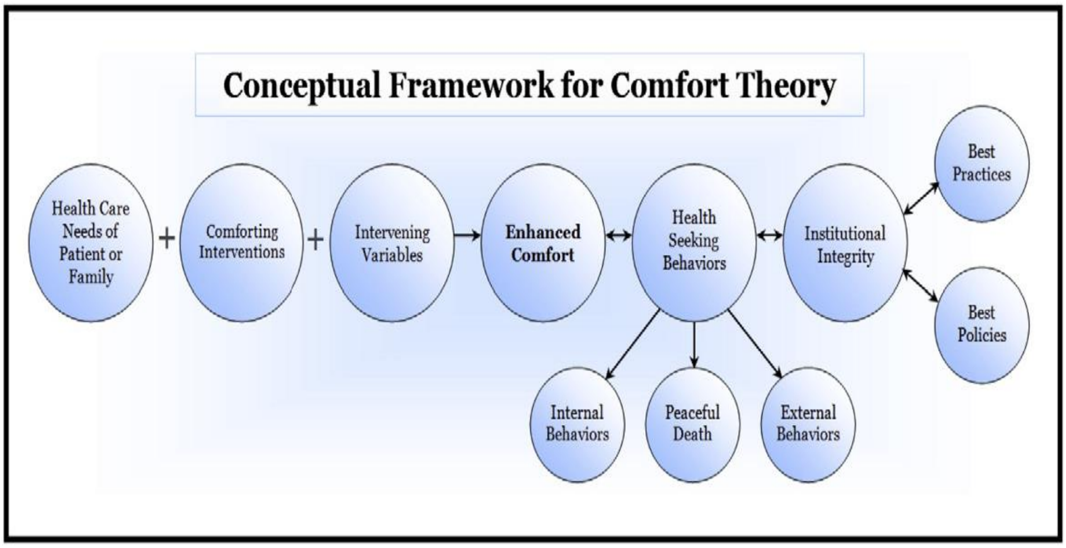


Figure 1: Conceptual Framework

Source: Kolcaba et al., 2006

Health Care needs of patient or family: health deficit arising from stressful health care situations where the body fails to meet demands.

Comforting intervention: comforting measures put in place by the nurse to meet health care needs of the terminally ill client.

Intervening variables: include but not limited to age, gender, civil status variables brought to nurses by clients cannot change.

Enhanced comfort: ease, relief, and transcendence in the physical, sociocultural, psycho-spiritual and environmental context. If enhanced comfort is achieved, clients will be motivated to participate in health seeking behaviour or gain a peaceful death.

Health seeking behaviours (internal behaviours, external behaviours, and peaceful death): actions to promote optimal wellness, recovery, rehabilitation and/or peaceful death, can be external or internal. Health seeking behaviours lead to the utilisation of health care facilities and services. In turn, this will help improve the health care system, helping more patients to become better.

Institutional integrity: means best practices and best policies**.** Better healthcare system ensures better progress and implementation of best policies and practices in health care.

Nurses must have knowledge on end-of-life stages and care in order to provide quality, effective care to the patients and families going through this process. The knowledge must reflect evidence-based practice, therapeutic communication, and background on the stages of end-of-life. Skills must demonstrate genuine, caring touch. This type of environment is delicate and the patient must be treated with respect. Skills in communication is important not only with patients, but most importantly with patients' family. Attitude felt by nursing staff must be acknowledged. It is imperative to know that nurses' ought to deny discrimination among patients and their families in order to meet needed care for patients and their families. Healthcare staff can take a retrospective evaluation to care that is being rendered to vulnerable population.

Everyone experiences death at some point in life. Nurses need to have knowledge on end-of-life and palliative care in order to improve the quality of the care they give. Nurses need to be aware that patients and families deal with different traumatic events in different ways. Applying Kolcaba's theory of comfort will allow nurses to provide the best treatment for each individual patient. By having knowledge in this theory nurses can apply ideas in the plan of care for end-of-life patients. For patients and their families, end-of-life can be very stressful and many do not know what to expect, thus end-of-life can mean different things to patients and their families based on their cultural beliefs. Nurses can further their knowledge for patients during end-of-life care which will improve care given.

Conceptual Framework

To come out with a sound research, there must be a clear conceptual framework that spearheads the research process. According to Fisher (2007), researchers are not precluded from adapting existing conceptual framework, however, suitable amendments are expected to meet the context and research questions of their studies. Fisher further elaborated that a well-constructed conceptual frame work ought to be put in writing. The conceptual framework guiding the study is presented in figure 2 below.

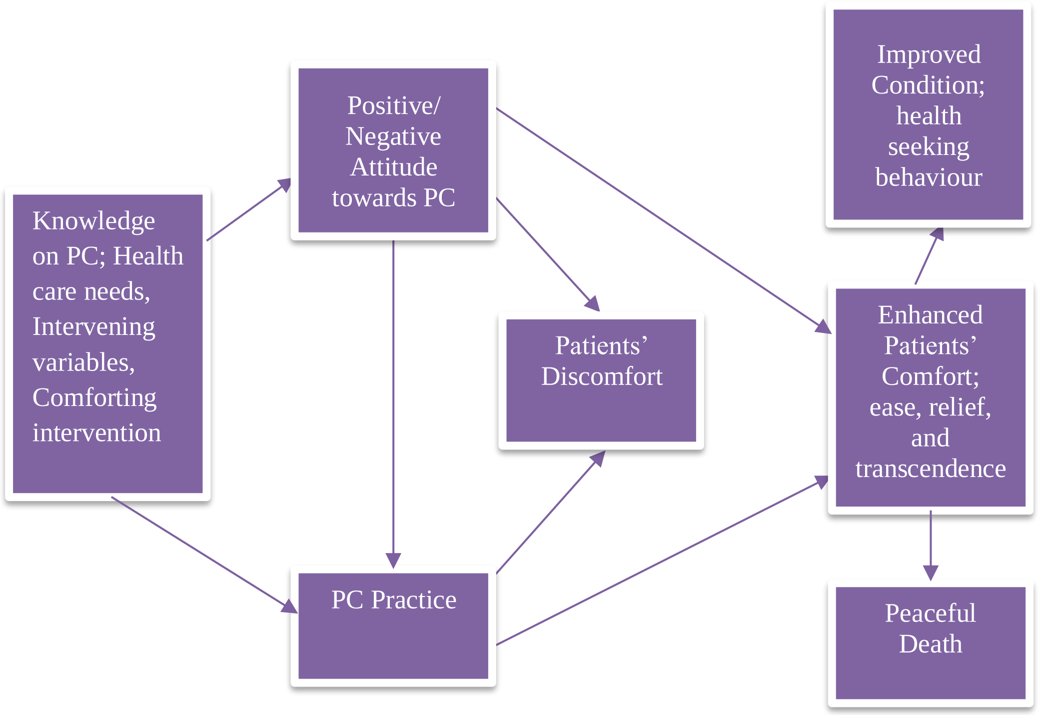


Figure 2: Conceptual Framework Guiding the Study

Source: Adapted from Kolcabas' Conceptual Framework

The framework examines the associations among the variables (Knowledge, Attitude, Practice) used in the study. It explicitly shows how the variables relate in solving the research questions. The study was to assess the knowledge, attitude and practice of PC among nurses. From the frame work, Knowledge refers to awareness or understanding a nurse has regarding palliative and end of life care (Kolcaba et al., 2006). This means that nurses must be aware of the health care needs, intervening variables, comforting intervention needed in caring for terminally ill patients. Therefore, higher level of knowledge regarding palliative care will lead to positive attitude and acceptable palliative practices, whiles lower level of palliative care knowledge will result in negative attitude and unacceptable palliative practices.

Nurse attitudes toward PC signifies the set of emotions, beliefs, and behaviours toward a dying patient. Positive attitude towards a dying patient will enhance comfort, while negative attitude towards a dying patient will promote discomfort. This is to say that the attitude of nurses towards PC will either enhances their practice or not. PC Practices is seen as the necessary actions taken by nurses to aid PC. Common practices include referral, pain management, use of drugs to assist peaceful death, and withdrawing life support as favourable practice for unavoidable death. Nurses provide peaceful bedside scenes after death, and teach patients' families the manner of acting around a dying patient, and also provide support to families after the death of a patient. Good PC practices will enhance comfort. However, bad PC practices will lead to discomfort which is body or mental distress.

Comfort is achieved as explained by Kolcaba (2003) when there is a relief, ease and transcendence. Palliative care practices that relieve patients from pains will lead to improved condition of the patient. That is there would be positive changes in a patients’ condition emanating from adherence of patients to medication, or visiting health care facility**.** For instance**,** patients recover from pains or ailment after receiving medication. Hence, develops health seeking behaviour.

More so, good PC practices and positive attitude could result in peaceful death. This include desires for a particular dying process, pain-free status, having religious status, having dignity and wealth, having emotional well-being, life completion, treatment preferences, family, quality of life, and good relationship with health care givers before dying (Meier et al., 2016).

Overview of Palliative and End-of-Life Care

The word ‘palliative’ has its origins in the Latin word ‘pallium’ meaning to cloak or cover. It focuses on minimising the progression of a disease and relieving undesirable symptoms for as long as possible, rather than attempting to cure the (usually incurable) disease (Becker, 2009). PC began with a focus on the care of the dying. PC means different things to different people, and modern definitions are rapidly evolving.

WHO has defined palliative care as care that affirms life and regards dying as a normal process, neither hastens nor postpones death, and provides relief from pain and other distressing symptoms, WHO (as cited in Becker, 2009). The emphasis is on symptom management in the dying patient, with no effort to prolong or hasten death. WHO’s definition appears to be synonymous with the NCfPC (2002) definition of palliative care which seeks to affirm life and regard dying as a normal process; provides relief from pain and other symptoms; integrates the psychological and spiritual aspects of patient care; offers a support system to help patients live as actively as possible until death; offers a support system to help the family cope during the patient’s illness. A more contemporary and simple definition of PC is to alleviate the sufferings of patients without providing a cure (Macpherson, 2002).

Pope (2013) also asserted PC as a strategy that helps patients and families who desire discontinuity of advanced treatments, or who have no alternative to treatment because of their disease process or quality of life. Nurses require good knowledge, attitude and practice regarding PC so as to provide quality care at terminal stage of life or for patients with chronic sickness.

Palliative care finds its true origin from care rendered by nursing pioneers such as Florence Nightingale and Dame Cicely Saunders in the early 1800s. They cared for the emotional, spiritual, physical and psychological needs of patients. There was, however, no formal title given to this type of care, except for that of nursing care (Saunders, 2001). It became apparent in the 1960's through observations by the pioneers that when a cure was not possible, the available technology needed to care must be used to alleviate pain.

Dr. Cicely Saunders first articulated her ideas about modern hospice care in the late 1950s based on the careful observation of dying patients. She advocated that only an interdisciplinary team could relieve the total pain of a dying person in the context of his or her family, and the team concept is still at the heart of palliative care (Loscalzo, 2008). The art and the science of caring for dying patients and their families has long been recognised as an immensely demanding and rewarding part of health and social care. For nurses, it is central to the values and principles that underpin clinical practice (Becker, 2009).

The values and beliefs that underpin high-quality palliative care are integral to good nursing care. Nurses are in a unique situation as the only real 24-hour care takers in the healthcare system to incorporate and develop the principles and practice of the palliative approach into their daily work where it is appropriate to do so. The challenge to nurses involved in end-of-life care is how to combine the art and the science into a cohesive approach that reflects individuality, choice, dignity and compassion in whatever environment care takes place (Becker, 2009).

Principles of Palliative Care

Palliative care activities work on the following principles;

1. Affirms life and regards dying as a normal process
2. Neither hastens nor postpones death
3. Provides relief from pain and other distressing symptoms
4. Integrates the psychological and spiritual aspects of care
5. Offers a support system to help patients live as actively as possible until death
6. Offers a support system to help patients' families cope during the patient's illness and in their own bereavement

Components of Palliative Care

Essential components of palliative care include symptom control, effective communication with patients and their families, continuity of care, terminal care, and support in bereavement, education, and research. Rehabilitation with the aim of maximising independence is also vital to good care. As disease progresses, continuity of care becomes increasingly important as well as coordination between services is required. Information must also be transferred promptly and efficiently between professionals in the community, hospitals, and hospices (O’Neill & Fallon, 1997).

Level of Palliative Care Development in Countries

Lynch, Connor, and Clark (2013), have provided a well understood classification system to crystallise levels of palliative care development in some selected African countries. Lynch, Connor and Clark classified the selected countries in four groups with Group 3 and Group 4 having two compositions, thus Group 3a and Group 3b, and Group 4a and Group 4b. According to Lynch, Connor and Clark, Group 1 constitutes African countries without any hospice or palliative care activity.

Group 2 on the other hand encompasses African countries distant from any palliative or hospice care service. However, such nations have evidence of larger initiatives designed for organisation, workforce, and policy capacity arrayed towards development of hospice-palliative care services. According to the authors the developmental activities encompass attendance at or organisation of crucial conferences; personnel embarking on external training regarding palliative care, and incipient service development.

Group 3a is described by the authors to have isolated palliative care provision. The authors explain that countries within this category are earmarked with development of palliative care activism with less support. These nations depend mainly on donations to finance palliative care services. They have little drugs for pain management which are often available at home-based care.

Palliative care activities in Group 3b are generic in nature. Countries are characterised with development of palliative care activism in various locations that have emerging local support and multiple financial supports. Group 3b nations have independent health care providers whose activities are isolated from the nations' official designed health care system. Nations have adequate drugs for pain management, and provide some training and education initiatives.

Lynch et al. (2013) aver that Group 4a category of countries is primarily integrating hospice/palliative care into mainstream health care services. This group is also noted to have development of crucial mass palliative care activism in many locations. Countries within this category have diverse palliative care givers with several services. Countries are characterised with development of a crucial number of palliative care activism in a number of locations; a variety of palliative care providers and types of services. Health professionals and local communities are aware of palliative care. More so, drugs for pain management are adequate. Besides, Group 4a countries have limited impact of palliative care on policy, and provision of significant number of training and education initiatives by several organizations. These countries have existing, or are interested in formation of national palliative care associations.

The features of Group 4b include advance integration of hospice or palliative care service into mainstream healthcare service provision. Authors argue that this category of countries have development of crucial mass palliative care activism in a larger number of locations. They also have comprehensive provision of all kinds of palliative care and diverse care givers, health professionals, local communities, and society in general have wider awareness of palliative care. Drugs for pain management are unrestrictedly availability. Group 4a nations are attributed to have substantial impact of palliative care on policy, especially on public health policy; also have well established education centres like universities. Countries have existence of national palliative care association.

Based on this classification system, in 2011, Ajayi et al. (2014) in the study "Palliative care research in West Africa" categorised 16 African countries based on their level of PC service development. According to Ajayi et al., the majority of West African countries had no known palliative care activity. The most advanced country was Côte d'Ivoire, classified as having generalised palliative care provision. No country had hospice or palliative care services that were in the process of being integrated into mainstream healthcare services. Ghana was captured under Group 3a as having isolated palliative care provision (see Table 1).

Table 1: Levels of palliative care service development in West Africa

Group 1: No known activity		**Group3a: Isolated palliative care provision**	**Group3b: Generalized palliative care provision**
Benin	Niger	Gambia	Côte d'Ivoire
Burkina Faso	Senegal	Ghana	
Guinea	Togo	Mali	
Mauritania	Guinea-Bissau	Nigeria	
Liberia	Cape Verde	Sierra Leone	

Source: (Ajayi et al., 2014)

In Ghana, there were no palliative care activities until 2003, when the need to provide palliative care was raised by the then Minister of Health, Dr. Kwaku Afriyie in September 2003. Ripples Health Care was established to provide specialist palliative care to terminally ill patients with cancer, diabetes, stroke and other life-limiting illnesses. The Ghana Palliative Care Association was founded in 2006. There have been periodic training sessions, such as that held in 2009 with support from a UK-based non-governmental organisation (Ajayi et al., 2014).

Quality of Health Care at End-of-Life Care

Quality of health care at the end-of-life has been emphasized in nursing in the last two decades because of the increase in the number of patients with chronic illnesses who are dying in hospitals or long-term care facilities. At the end-of-life stage, patients often have symptoms or impairments resulting from the underlying altered body systems (National Institutes of Health [NIH], 2012) that require complex nursing care interventions. Health care may have a considerable impact on quality of life at the terminal stage of illness, thus health care seems to have appreciable relationship with an individual's quality of life. According to Dunn, Otten, and Stephens (2005) it is important to provide professional and quality care for terminal patients and their families.

The concept "quality of life" is a multidimensional and multidisciplinary in nature, and its effects transpire to a larger aspect of human life: psychosocial, spiritual, financial, and physical life experiences. For cancer patients, the physical constituent of quality of life experience is determined by the extent of management or control of symptoms such as pain, fatigue, nausea, and other related symptoms. One integral aspect of quality of life that is of concern to patients at the end-of-life is the psychosocial distress and alarm concerning loss of function, fear of future uncertainty, expectation about physical perils, or even death relating to serious disease like cancer (Payne, Medina, & Hampton, 2003). According to Payne et al., psychosocial and emotional constituent of quality of life usually come together with spiritual issues.

Palliative care is an integral component of healthcare that focuses on terminal ill patients. It aims at obviating or relieving physical, psychological, social, emotional and spiritual distress and improving the quality of life for patients and their families (Nelson et al., 2004; Payne et al., 2003).

The Need for Palliative and End-of-Life Care

De-Vlieger, Gorchs, Lankin, and Porschet (2004) emphasized that palliative care is an integral part of nursing care which can be performed at different realms of complexity. The concept was historically seen as intensive care given to patients with terminal illness, however, recent knowledge about palliative includes treatment given to patients who are likely to live many years with end stage organ failure or cancer (Sanderson & Tieman, 2010).

According to Skår (2010) the knowledge, attitudes, beliefs and the experiences of health care professionals is one of the pertinent determinants of successful administration of palliative health care, which determines professionals' procedures and behaviours in the process of evaluation and treatment of patients. Kassa et al. (2014) consented to Skår by indicating that to promote quality health care at terminal stage of life or for patients engraved with chronic sickness, nurses require good knowledge, attitude and practice regarding palliative care in order to provide quality health care at terminal stage of life.

Hunt (2008) argues that palliative care demands a collaborative effort from a team of health professional which includes nurses, social workers, physicians, psychologist, pharmacists, spiritual counsellor, and voluntaries of which each professional has a peculiar function to perform. Among these classes of professionals, nurses are the most valuable professionals in palliative care team who address the physical, functional, social, and spiritual dimensions of care (Das & Haseena 2015; Egan & Abbott, 2002). The reason behind this assertion was uncovered by Razban, Iranmanesh, and Rafiei (2013), who argued that nurses are the category of palliative health team that spend the greatest number of times with patients. The prolong exposure of nurses with patients provides a spectacular opportunity to have adequate knowledge and understanding among the patients and those providing health care services (White, Coyne, & Patel 2001).

However, studies indicate that critical care nurses have poor knowledge regarding palliative care in general and management of signs and symptoms in particular. Critical care nurses are known to have poor knowledge concerning provision of support to, communication with, and spiritual needs of patients and their families (Institute of Medicine [IOM], 2003; Pritchard & Davies, 2002). The lack of knowledge regarding palliative health care is a challenge to nurses and other health professional in their palliative care endeavours (Norlandar, 2008).

The evolvement of palliative care in West Africa has not been primary in comparison to evolvements in the eastern and southern parts of the continent (Ajayi et al., 2014). The concept of palliative care in Sub-Saharan Africa is relatively new (Downing, Powell, & Mawangi-Powell, 2010), and palliative care is greatly circumscribed to isolated specialist centers (Harding & Higginson, 2004). In Harding and Higginson (2005), it was argued that pain, symptoms control and end of life care are crucial for quality HIV and cancer care in Sub-Saharan Africa. Notwithstanding, the definition of feasible, accessible, and effective palliative care, and their services development are matters of challenge in Sub-Sahara Africa.

Knowledge, Attitude and Practice of Palliative and End-of-Care

Literature reveals that palliative care knowledge and end-of-life care is considered low among nurses (Basal & Younis, 2017; Nakazawa et al., 2009; Prem et al, 2017; Sorifa & Mosphea. 2015). A cross-sectional quantitative study by Kassa et al. (2014) in Ethiopia affirms that palliative care and the nature of palliative services offered are concepts that are new and less known among Ethiopian nurses. The study revealed that 104 (30.5%) out 341 informants had good knowledge of PC. This signifies that, majority of the informants 237 (69.5%) had poor knowledge of PC. According to authors, the reason for this might be that only few nurses have been trained on PC.

The significance of knowledge deficit of palliative care has been emphasized by other studies (Kassa et al., 2014; Sorifa & Mosphea, 2015; Sarfo et al., 2016) with inadequate training on PC as a major setback. According to Abu-Saad and Dimassi (2007), a study on palliative care conducted in Lebanon majority of nurses believed terminally ill patients and their families should be informed of the diagnosis and prognosis, however only 19% of respondents had knowledge on PC.

Similarly, a study conducted by Ayed et al. (2015) in Palestine revealed that only 20.8 % of the overall respondent rate had good knowledge regarding palliative care. The authors used a self-administered questionnaire developed by the researchers to solicit data from 120 full time nurses working at Intensive Care Unit (ICU), Emergency Room (ER), Medical or Surgical wards. The low level of nurses' knowledge about palliative care in this study could be associated with the lack of specific palliative care units in Palestine and lack of updating information regarding palliative care, and this might be due to the fact that PC education was not incorporated into either diploma or degree curricula.

In 2008, an analytical cross-sectional was conducted by Ronaldson et al. (2008) to identify residential aged care nurses' knowledge of palliative care for older residents in need of end-of-life care. The study used a validated questionnaire tool - Palliative Care Quiz for Nursing(PCQN) combined with a demographic survey of Registered Nurses and Assistants in Nursing (AINs) working in five high care residential aged care facilities in inner city region of Sydney, Australia. The results revealed that the mean score for Registered Nurses was 11.7 (SD 3.1) and for AINs 5.8 (SD 3.3), the difference between scores being significant (t = 8.7, df = 95, P < 0.01). A quantitative, descriptive cross-sectional survey conducted by Al Qadire (2014) in Jordan revealed a mean score of 8.3 (2.8). All indicating low knowledge of PC among nurses which may be due to misconceptions and inadequate education with regards to PC.

Contrary to this argument is the result of a cross-sectional descriptive study by Pan et al. (2017), which indicated a better palliative care services at haematology and oncology ward. According to Pan et al., higher level of knowledge (M=16.5, SD=2.3) toward PC was associated with working in haematology and oncology wards, and also participation in education related to palliative care. Findings of qualitative survey study by Knapp et al. (2009) supports this by indicating that Paediatric nursing workers in Florida have a good level of baseline knowledge regarding palliative care.

From the above findings, majority of the studies indicated that nurses do not have adequate knowledge in caring for terminally ill or dying patient. So, the question; do nurses at CCTH have adequate knowledge in PC to care for terminally ill patient?

More so, the quality of health care provision is influenced by the attitude of nurses regarding caring for dying patients (Mastroianni et al., 2015). Nurses' attitudes toward end-of-life care affect their decision making regarding palliative care (Latour, Fullbrook, & Albarran, 2009).

According to Kassa et al. (2014), nursing staff at non-governmental health facility (Hayat Hospital) had a 71.5% susceptibility of having negative attitude towards palliative care than nursing staff at government facility (Black Lion Hospital). This may be as a result of nurses at government hospital receives more training on end-of-life care. More so, a descriptive correlational study by Dunn et al. (2005), revealed that, nurses show positive attitude towards caring for terminal patients. In a cross-sectional descriptive study by Pan et al. (2017), it was argued that respondents have a positive nursing attitude towards palliative care consultation services in Taiwan. The argument was confirmed in a cross-sectional qualitative study conducted by Kassa et al. (2014) which pinpointed that 76% of the respondents had favourable attitude towards palliative care. This also was affirmed by Das and Haseena (2015) which indicates that majority of the respondents 159 (79.5%) out of 200 had favourable attitude toward end of life care. The attitude of nurses towards palliative care may be affected by several factors; these factors allow nurses to either behave positively or negatively towards palliative and terminally ill patients. The type of health facility in which a nurse works and the social status of patients may also affect his or her attitude towards dying patients.

Contrary to these are the findings of a descriptive cross-sectional study Quebec by Leclerc, Bechennec, Le gal, Benoit, & Bellerose (2014) which indicated that a greater percentage of overall nurses have a negative attitude regarding terminally ill care. According to Leclerc et al., death is a taboo subject in Quebic society. Workers need to demonstrate empathy with their residents, be compassionate, and be willing to take the risk of personal involvement. This may have resulted in negative attitude of nurses. Their argument was in line with Banu and Sultan (2013) which was conducted at two University hospitals and one State hospital in Turkey. The attitudes of Turkish nurses toward death and caring for dying patients were reported to be negative. Although the majority of nurses (85%) stated that they had received education on end of life, most of them (82%) were not comfortable talking about death.

Their argument is also supported in a cross-sectional study by Razban et al. (2013). The results indicated that the participants had moderately negative to neutral attitudes toward palliative care (total mean score 2.99 out of 5). Some cultural and organisational factors may cause nurses and student nurses to lack positive attitudes toward caring for palliative care. Among Iranian nurses, kinship relationships are an important factor that influences their caring behaviours (Iranmanesh et al., 2008). Another possible explanation of this finding may be the lack of palliative care education and specific training among Iranian nurses. Román, Sorribes, and Ezquerro (2001) also emphasized that nurses, generically, have slightly unfavourable pattern in attitudes regarding caring for dying patient. A more positive attitude was observed in older care givers. The positivity in attitude decreased from morning to night shift.

In conclusion, some nurses show favourable attitude towards terminally ill patients whiles others do not. More so, the attitude of the nurses is influenced by some factors such as; type of health facility in which a nurse works, the financial status of patients' family and many more. What is the attitude of nurses at CCTH toward terminally ill or dying patients?

Regarding the practices of PC among nurses, a study by Jünger et al. (2010) revealed that caretakers had high desire to engross in palliative care, and also regarded palliative care as an aspect of their profile. Sorifa and Mosphea (2015), revealed that 48% of respondent had adequate practice regarding palliative care while 43% of the respondents had moderate adequate practice and 9% of the respondents had inadequate practice. Contrarily, Basal and Younis (2017), argued that more than half (51.4%) and 25.7% of nurses in Medical and Oncology ICUs respectively had poor practice while more than one third (34.3%) and 40% of nurses in medical and oncology department respectively had good practice score. The paper revealed that most obstacles for providing palliative care are care-givers not having enough time to provide quality end of life. Basal and Younis (2017) argument is supported by Anteneh, Kassa, Demeke, and Guadu (2016) who revealed that 55.7% of nurses had poor practice regarding palliative care. In Latour et al., (2009), it was revealed that out of the 39% responses rate, 91·8% shown direct participation in terminal ill care; 73·4% of the total respondents indicated active participation in decision-making process.

Pain management seems to be one of the commonness practices among nurses. Puntillo et al. (2014) revealed that almost every respondent in their study supported pain management and withholding, or withdrawing life support as favourable practice for unavoidable death. Iranmanesh, Razban, and Rafiei, (2014) indicated that the highest correct response was demonstrated by management of pain and other symptoms, which represented 46.07% of the entire response rate. Health caregivers use different drugs in their attempt to manage pain.

Nurses in their practice may assist terminally ill patients to die peacefully with the use of drugs. Heide, Rietjens, Hauser, and Emanuel (2007) emphasized that neuromuscular relaxants or barbiturates was used in ending life in 73.9% of all euthanasia or assisted suicide cases whilst 16.2% of all cases reported in 2005 was aided with opioids. Contrary to this finding, Puntillo et al. (2014) indicated that greater percentage of informant disagreed with assisted suicide, voluntary euthanasia and non-voluntary euthanasia. Latour et al. (2009) also argued that 98.8% of nurses in Europe showed their willingness to provide continuous pain relief and 91·3% approved open visiting whilst 65% of the respondents ensured reducing the flow of inspired oxygen.

In a follow-up study by Heide et al. (2007) on euthanasia, caregivers-assisted suicide, and other end of life practices corresponding to an act regulating activities of caregivers ending the life of unbearable suffering patients in Netherland who had requested an end of life illuminated that among the total death in Netherland in 2005, euthanasia and caregivers-assisted suicide accounted for 1.7% and 0.1% respectively. The author further revealed that 7.1% of the total deaths in 2005 were aided by physicians with the use of continuous deep sedation and possible hastening of death. This assertion of the use of sedation was agreed by Latour et al. (2009) in their study conducted in European intensive care units.

There are instances where caregivers do not want to involve neither the dying patients nor their families in end-of-life decisions. The result of Heide et al. (2007) indicated that 0.4% of the overall death was explained to be end of life in the absence of an explicit request from patients. Bradley et al. (2002) supported this assertion by indicating that caregivers overlook terminally ill patients' wishes. A regression results by Latour et al. (2009), revealed that 78·6% of nurses shown their allegiance of involving family members in end of life decisions. Some nurses disregard the discussion of death with patients. Banu and Sultan (2013) stated that, despite the fact that 85% of the respondents indicated their education on terminally illness, 82% of the respondents were discomforted about discussing death with terminally ill patients.

Nurses may sometime prefer isolating dying patients from other patients. Latour et al. (2009) argued that 78% of the respondents disagreed the idea of isolating dying patients in a single room. According to Harding and Higginson (2004) cases in Africa shows that patients may be isolated from people in the village with idea of avoiding spread of the disease. Patients may be discharged from hospital to the community with the aim of preventing dangers of crowded wards and toxic Western drugs.

In Sub-Saharan Africa, a survey by Adamolekun (1998) in Nigeria revealed that in spite of the believe by more than half of the respondents regarding disclosure of prognosis to patients, 73% of doctors and 89% of nurses denied prognosis from terminally ill patients. Kassa et al. (2014) also indicated that almost half of the informants reported that the diagnosis of patients was usually performed at the terminal stage by taken into account the spiritual and medical conditions of the terminally ill patient.

The review indicates that most nurses adequately practice PC. Hence, to what extent do nurses at CCTH practice PC?

Relationship between Variables (Knowledge, Attitude and Practice) of Palliative and End-of-Care among Nurses.

Most studies have assessed the relationship between the various variables used in the study. Ayed et al. (2015) in a study revealed that 20.8% of the total respondent had good knowledge of palliative care and 59.4% had training on palliative care. This explicitly indicates that fewer of the respondents were given palliative care training and hence the lower knowledge level among nurses.

A descriptive study by Choi, Lee, sun Kim, Kim and Kim (2012) also identified that there was a statistically significant difference between respondents exposed to end-of-life care education and those without. Participants who had the end of-life care education (M = 9.57, SD = 2.19) tended to score higher than those without this education (M = 8.47, SD = 2.34) and the difference was statistically significant ($p < .001$). This is also supported by Kim et al. (2011) which indicated that participant with associate degrees scored significantly lower than those with masters and doctoral degrees. This signifies that as education on end-of-life care increases, nurses' knowledge on PC also increases.

This, however, opposes the findings of Wilson, Avalos, and Dowling (2016). A cross-sectional survey by the authors pinpointed that palliative care training has zero influence on the mean overall scores, instead there was a positive correlation between respondents' level of knowledge regarding palliative care. The results of Storey and Ziemba-Davis (2013) support that nurses have moderate knowledge of palliative care but not full knowledge.

Moreover, in a study conducted by Román et al. (2001), nurses with positive attitude regarding caring for dying patients were those having a longer year of working exposure, and those having morning shift. This argument was supported by Iranmanesh, Dargahi and Abbaszadeh (2008). The results of Banu and Sultan (2013) also revealed that there is a significant association among nurses' education level, willingness to provide terminally ill care and scores on Frommelts' Attitude towards Caring for Dying Patients and on Death Attitude Profile- Revised subscale of $P < 0.05$. The research findings of Mastroianni et al. (2015), Pan et al. (2017) and Kassa et al. (2014) have direct support to this argument. However, Kassa et al. added that institution and training have significant relationship with attitude of nurses.

A study by Razban et al. (2013) pinpointed a significant correlation between nursing staff's attitudes regarding palliative care and certain demographic features such as marital status, type of ward, palliative care education, and personal study about palliative care, education level, and caring experience. A digression finding by Dunn et al. (2005) included a zero significant association between the attitude of nurses concerning death and attitudes of nurses regarding terminally ill care.

Nurses' level of palliative knowledge may influence their attitude towards palliative patients. A descriptive study by Das & Haseena (2015) revealed a 0.272 correlation co-efficient value indicating a weak positive correlation between knowledge score and attitude score of staff nurses regarding palliative care. A significant correlation was found between nurses' palliative knowledge and attitudes regarding death and dying in Africa traditions. This, however, has significantly influence on the accepted models and places for the terminally care. Africans considered traditional healers as the primary help for the terminally ill (Harding & Higginson, 2004).

Sorifa and Mosphea (2015) showed that there is a positive relationship between knowledge and practice scores of palliative care among nurses, with a correlation of ($r = 0.30$, $p < 0.001$). The study revealed that there was a direct relationship between knowledge and practice with all the age group and professional qualification. However, there existed an inverse relationship between knowledge and practice of staff with lesser and highest working exposure.

In Eastern Ethiopia, a study conducted by Meaza and Worku (2012) using a cross sectional descriptive survey and the data was collected with a self-administered questionnaire from 197 nurses. The study revealed that 56% had good knowledge and 88.3 % of them had favourable attitude towards palliative care. The study showed that there is no significant association between knowledge of palliative care and age, sex and experiences of the nurses ($P > 0.05$). There was a positive correlation between knowledge and attitude regarding palliative care ($r = 0.268$, $p < 0.001$) which was statistically significant.

According to Bradley et al. (2002) attitudes typifying support for hospice practices and philosophy were related to referral practices in adjusted and unadjusted analyses with adjusted odds ratio of 0.52, and 95% confidence interval (CI: 0.35, 0.77). Beckstrand and Kirchhoff (2005) indicated that the supportive behaviours demonstrated towards family members were granting substantial time for their patients after death, providing peaceful bedside scenes after death, and teaching patients' families the manner of acting around a dying patient.

Barriers to Palliative and End-of-Life Care Practices

The problem of poor knowledge of palliative care and end of life care is attributed to several factors. According to a report by World Health Organization in 2005 (as cited in Knapp et al., 2009), lack of trained personnel, particularly health providers and social workers, lack of a multidisciplinary palliative care team, poor discernment regarding palliative care on the part of health providers, and shortage of hospices and day care centers pose challenges that underpin palliative care activities. The report further indicated that insufficient regulatory framework, insufficient financial resources for palliative care activities, insufficient training for home-based care givers, dilapidated physical health facilities, inadequate pain treatment procedures, and less adequate national palliative care strategy are other obstacles to palliative health care.

A study conducted by Born and Greiner (2004) revealed that closely tied to access to care was the barrier to end of life care. Born and Greiner, concluded that lack of awareness of hospice; prohibitive cost of health care; language barriers and lack of confidence in the health care system were the barriers to hospice care. According to Born et al., Latinos had a greater likelihood of reporting language as barriers to end-of-life care. In connection with language barrier, Granek, Krzyzanowska, and Tozer (2013), emphasized that poor communication has a serious adverse implication on palliative care.

A study by Basal and Younis (2017) in Egypt revealed that limited time to provide quality end-of-life was the main obstacle to palliative care. This assertion was supported by Jünger et al. (2010). The authors however, added that financial burden, sole responsibility in the absence of team support, and formal requirements like forms and prescriptions are other obstacles to palliative care. In a cross-sectional postal survey by Rhee et al. (2007) in Australia, it was revealed that the major barrier underpinning general professionals from participating in palliative care included lack of interest, knowledge, home visit, and problems with after-hours care` resulting from commitment to self and family. In Beckstrand and Kirchhoff (2005), the highest scoring obstacles were revealed to be frequent telephone calls from relatives of patients for enquiries, patients' families who misconstrued the term lifesaving measures, and physicians’ disagreement regarding the direction of a terminally ill care.

The obstacle to palliative and end-of-life care in Africa can be ascribed to inadequate diagnostic facilities and assessment skills, poor availability of chemotherapy and radiotherapy, and absence of opioids (Soyannwo & Amanor-Boadu, 2001). This assertion is in line with the findings of Harding and Higginson (2004). The authors indicated that the challenge of palliative care sustainability in African continent includes lack of infrastructures and resources such as low clinical training, and inadequate regulation on procurement of drugs.

Chapter Summary

The purpose of this study was to describe the nurses' knowledge, attitudes, and practices regarding palliative care and to determine whether or not the existing literature supports the above research questions. PC was seen as the art and science of caring for dying patients and their families has long been recognised as an immensely demanding and rewarding part of health and social care. However, the challenge to nurses involved in end-of-life care is how to combine the art and the science into a cohesive approach that reflects individuality, choice, dignity and compassion in whatever environment care takes place. Ajayi et al. (2014) in a study showed that, Ghana was having isolated palliative care provision which aims at obviating or relieving physical, psychological, social, emotional and spiritual distress and improving the quality of life for patients and their families.

The literature analyses also showed that, majority of nurses do not have adequate knowledge in caring for terminally ill or dying patient. Also, some nurses have favourable attitude towards terminally ill patients whiles others do not. More so, the attitude of nurses is influenced by some factors such as; type of health facility in which a nurse works, the financial status of patients' family and many more. Nurses who applied palliative care knowledge into practice were those who have had palliative care training and education. Nevertheless, literature revealed that, applying kolcabas' theory of comfort will allow nurses to provide the best treatment for each individual patient. Again, it also revealed that, there is a geographical gap in palliative care research since majority of the studies was done in different countries other than Ghanaian settings. The next chapter (Three) elaborates on the research methods employed for the study.

CHAPTER THREE

RESEARCH METHODS

Introduction

This chapter presents information regarding the procedures that were used in conducting the study. The chapter is organised under the following sections: research design, population, sample and sampling procedure, instrument, pretesting of instrument, reliability of instrument, data collection procedure, ethical issues and data analysis. The main rationale for the study is to assess the practices of palliative and end of life care among nurses at Cape Coast Teaching Hospital

Research Design

The researcher utilised cross-sectional analytic design for the study. The cross-sectional research design was deemed best for the study because, according to Cohen, Manion, and Morrison (2007), in cross-sectional design, researchers gather data at a particular point in time with the intention of describing and the nature of existing conditions or identifying standards against which existing conditions can be compared. As recommended by Leedy and Omrod (2010), this method is suitable for purposes of making generalisations from a sample to a population so that inferences could be made about the characteristics, knowledge, opinions, attitudes, practice, and past experiences of the population. Cross-sectional analytic design provides a more accurate and meaningful picture of an event or phenomenon and seeks to explain people's perception and behaviour on the basis of data gathered at a particular time and has been used by several authors (Saunders, Lewis & Thornhill, 2009; De Vos, Strydom, Fouche & Delport, 2011).

The cross-sectional research design was deemed best for the study because according to Kumekpor (2002), is a design in which data on sample or “cross section” of respondent are chosen to represent a particular target population at essentially one point in time. So, the design was appropriate for the researcher to elicit information from nurses about the knowledge, attitude and practice of PC from sample of a total population of nurses.

Irrespective of the strengths of the cross-sectional survey mentioned above, Fraenkel, Wallen, and Hyun (2012) identified difficulty in ensuring that the questions to be answered are clear and not misleading, getting respondents to answer questions thoughtfully and honestly is a setback, and getting a sufficient number of questionnaires completed and returned so that meaningful analysis can be made is also a setback for the descriptive survey. It is also susceptible to bias due to low response and misclassification due to recall bias (Hennekens & Buring, 1997; Henn, Weinstein, & Foard, 2006). Osuola (2001) in buttressing the points on the weaknesses of the cross-sectional research, pointed out that, in other to design a quality investigation, it requires particular attention to two central factors which involved appropriate sampling procedures, and precision in defining terms in eliciting information. More so, he added that, while cross-sectional research is a prerequisite for finding answers to questions, it is not in itself sufficiently comprehensive in providing answers and that it cannot also provide cause-and-effect relationships (Osuola, 2001).

Notwithstanding the difficulties and setbacks of cross-sectional survey design indicated above, it was still deemed most appropriate and applicable for the study. It helped the researcher to gather accurate data on nurses regarding knowledge, attitude, PC practices among nurses at CCTH and also to answer the various research questions.

Study Setting

Among the several hospitals in the Central Region of Ghana which are mainly primary and secondary healthcare provider (aims at providing curative and preventive treatment), Cape Coast Teaching Hospital popularly known as “Interberton” in Cape Coast-Ghana (tertiary healthcare provider) was used for the study. This is because, it is the largest hospital in the region and the major teaching hospital with a referral capacity in Cape Coast, which has diverse categories of nurses and patients based on specialty units and can provide PC services. The Hospital, which was the first of a series of ultra-modern Regional Hospitals established by the Ministry of Health, started full operations on 12th August, 1998 and was adjudged the best Regional Hospital in the year 2003 (CCTH, 2016).

The hospital provides specialty care in ophthalmology, paediatrics, general surgery and internal medicine and many more which attracts patients from all parts of the country (CCTH, 2016). It is also known for the care rendered to patients with end-stage kidney disease who are on dialysis. Regardless of these credentials, the hospital lacks specialised unit that provide end of life and palliative care as well as the knowledge, attitude, and practices of nurses in this hospital is not well established.

Study Population

Population refers to the large general group of many cases from which a researcher draws a sample and which is usually stated in theoretical terms (Neuman, 2003). Polit and Hungler (1998) defined a study population as that which reflects the entire aggregate of cases that meet designated set of criteria. According to Amedahe (2004), the target group about which a researcher is interested in gaining information and drawing conclusions is what is known as the population. It is a group of individuals who have one or more characteristics in common that are of interest to the researcher.

In this study, the target population was the set of registered and enrolled nurses at the Cape Coast Teaching Hospital since they are needed to provide information required to answer the various research questions. More so, nurses make the largest population in healthcare as they account for nearly 50% of the global health force (WHO, 2018). They are in the situation as 24-hour care takers in the healthcare system to incorporate and develop the principles and practice of the palliative approach into their daily work where it is appropriate to do so (Becker, 2009; Hopkinson et al., 2005). Cape Coast Teaching Hospital has an estimated nurses' population of 543 together with an estimated bed capacity referral of 400 (CCTH Health Informatics, 2018).

Sampling Procedure and Technique

Polit, Beck and Hungler (2010) define a sample as a proportion of a population. A carefully selected sample can provide data representative of the population from which it is drawn. Therefore, based on the target population, a carefully selected subset of the unit that comprises the target population was drawn to represent the sample of the study. The sample size for study was obtained by employing Slovins' formula (Israel, 1992; Tejad & Punzalan, 2012). The confidence level of 95 percent which will give a margin error of 0.05 was adopted.

$$n = \frac{N}{1+Ne^2} \qquad 1$$

Where: N = total population (543),

n = sample size,

e = Margin of error or error of tolerance = confidence level (0.05)

Therefore, n becomes

$$n = \frac{543}{1 + 543(0.05)^2}$$

n = 230

Therefore, the sample size for the study was 230 registered and enrolled nurses out of a total population of 543 nurses. Simple random sampling technique was used to select 230 nurses for the study. Simple random sampling is the most basic and common type of sampling method used in quantitative social science research and in scientific research generally (Saunders et al., 2009). The main benefit of the simple random sample is that each member of the population has an equal chance of being chosen for the study (Cohen et al., 2007; Saunders et al., 2009). This means that it guarantees the sample chosen to be representative of the population and that the sample is selected in an unbiased way.

In selecting the 230 nurses out of the total population of 543, the lottery method was used, hence every member had a chance of being selected. Each member of the population was numbered systematically and in a consequent manner by writing each number on a separate piece of paper. These pieces of paper were mixed and put into a container and then numbers were drawn out of the container without replacement in a random manner up until 230 sample was achieved. Each number corresponding to a member of the population was given the questionnaire to fill. It is worth to note here that, the sample size for fully completed questionnaires was 215 respondents since 15 of the questionnaires were incomplete.

Inclusion and Exclusion criteria

Registered and enrolled nurses who had worked at CCTH for at least six months were included in this particular study. It is assumed that, these nurses have at least had a chance to care for terminally ill patients. New nursing staff who had not work up to six months and nursing students were excluded in the study. Registered and enrolled nurses who had worked at CCTH for less than six months and student nurses were excluded in this particular study.

Data Collection Instruments

The questionnaire used comprised both close and open-ended items. The choice of questionnaire was based on the assertion of Cohen et al. (2007) that questionnaire is widely used and also useful for collecting survey information, providing structured, numerical data and being able to administer without the presence of the researcher. Osuola (2001) opined that questionnaires are “particularly advantageous whenever the sample size is large enough to make it uneconomical for reasons of time or funds to observe every subject”. More so, most of the study conducted on PC knowledge, attitude and practices employed the use of questionnaire to aid them access data to solve the research problem (Banu & Sultan, 2013; Mastroianni et al., 2015; Kassa et al., 2014; Pope, 2013).

The already developed questionnaire aided the researcher to answer the research question guiding the study.

The questionnaire consisted of five sections, A, B, C, D and E. The items on the questionnaire were mainly close-ended with only one item being open-ended. The greater proportion of close-ended items aid to produce data that can be analysed quantitatively for patterns and trends (Cohen et al., 2007). The agenda is to provide little flexibility for respondents to qualify their answers. The open-ended question allowed respondents the freedom to answer in their own words and therefore to provide greater qualification in their response. It revealed the pattern of respondents' strategies to curb the perceived barriers to palliative care practices at CCTH.

The first section (Section A) of the instrument consisted of the socio-demographic features of participants which entails nine (9) items required for the study. The second section (Section B) consisted of questions on knowledge. The Palliative Care Knowledge Instruments (PCQN) developed by Ross, McDonald and McGuiness (1996) was adapted for the study. Ross and colleagues administered the PCQN in Ontario, Canada, to a sample of 200 students and 196 nurses. Within the total sample, participants scored a mean of 61% on the final PCQN (Ross et al., 1996).

During the initial psychometric evaluation, Ross and colleagues assessed internal consistency and reliability using Cronbach's alpha. An acceptable level of internal consistency for the PCQN was reported as Cronbach's alpha ($\alpha = 0.78$) (Ross et al., 1996). The PCQN assesses PC knowledge among nurses in an objective manner (Pope, 2013). The tool consists of 20-scale items. The PCQN covers the following three categories in end-of-life care (Ross et al., 1996): philosophy and principles of palliative care (4 items), psychosocial aspects of care (3 items), and management and control of pain and other symptoms (13 items). The PCQN tool has been used in multiple studies since its development (Arber, 2001; Brazil et al., 2012; Knapp et al, 2009; Pope, 2013).

The third section (Section C) of the instrument concentrated on questions to assess the attitude of nurses towards palliative care. The Frommelt Attitudes toward Care of the Dying (FATCOD) Scale was developed by Frommelt (1991). The Frommelt Attitude toward Care of the Dying Scale (FATCOD) is one of the most valid, reliable (Frommelt, 1991; Frommelt, 2003), acceptable, and easy-to-fill instruments which was created for nurses and students of different health-care professions. FATCOD is a 30-item scale designed to measure participants' attitudes toward providing care to dying patients. While two-thirds of the statements address nurses' attitudes toward the dying patient, the other third address nurses' attitudes toward the patients' family (Frommelt, 2003).

The instrument is a 5-point Likert scale to indicate respondents' attitudes toward caring for dying patients which includes 15 positively (1, 2, 4, 10, 12, 16, 18, 20, 21, 22, 23, 24, 25, 27, and 30) and 15 negatively worded statements (3, 5, 6, 7, 8, 9, 11, 13, 14, 15, 17, 19, 26, 28, and 29) with response options: strongly disagree, disagree, uncertain, agree, and strongly agree. Positive items are scored one (strongly disagree) to five (strongly agree). Scores are reversed for negative items. A higher score indicates a more positive attitude toward caring for this patient population. Internal consistency of the tool was evaluated by Mastroianni et al. (2015) with Cronbach's alpha coefficient. The whole scale showed a satisfactory Cronbach's alpha coefficient of 0.75. The tool has since been used by authors to assess the attitude of nurses to end-of-life care (Mastroianni et al., 2015; Banu &Sultan, 2013).

Fourth section (Section D) of the questionnaire constituted 38 questions on practice of palliative care among nurses, while other questions on perceived barriers to PC practices (seven questions) and strategies to alleviate the barriers were captured in the fifth section (Section E) of the research instrument.

Pre-Testing of Instrument

The success of every research study depends, to a large extent, on the validity and reliability of the survey instrument. The instrument used for the study was already developed and pre-tested. Pre-testing of the instrument was carried out at Metro Hospital in Cape Coast. The aim of the pre-testing was to identify how easy the respondents could answer the questionnaire without difficulties. The participants for the pre-testing were asked to complete the questionnaire and to provide comments or suggestions for revising any unclear items.

I used simple random technique to select respondents for the pre-testing. Twenty registered and enrolled nurses were randomly selected to represent the population. This was done by numbering each member in a sequential manner. The numbers were written on pieces of papers and placed in a box. Numbers were randomly drawn from the box to select twenty respondents for the study. Each participant had a fair chance of being selected. The informants were asked to read and reveal any ambiguity noted. They were also to consider the structure, wording and length of the questionnaire, and alter the questions accordingly.

For instance, the following item were reworded; *"It is crucial for family members to remain at the bedside until death occurs*" to "*It is essential for family members to remain at the bedside until death occurs*"; "*The accumulation of losses renders burnout inevitable for those who seek work in palliative care*" to "*The accumulation of losses renders burnout unavoidable for those who seek work in palliative care*"; "*The loss of a distant or contentious relationship is easier to resolve than the loss of one that is close or intimate"* to "*The loss of a distant or quarrelsome relationship is easier to resolve than the loss of one that is close or intimate*"; "*Palliative care is appropriate only in situations where there is evidence of a downhill trajectory or deterioration*" to "*Palliative care is appropriate only in situations where there is evidence of a deterioration"* and "*Giving care to the dying person is a worthwhile experience*" to "*Giving care to the dying person is a worthy experience."* However, the modification had no noticeable effect on the reliability and validity of the findings because modified questions were true reflection of the original instrument.

A total of twenty (20) questionnaires were administered for the pre-testing exercise. Nineteen representing 95% of the total pre-testing questionnaires were retrieved. The reason for the non-retrieval of the one questionnaire was based on the fact that the nurse who was to fill the pre-test questionnaire was reported to have gone on maternity leave (travelled to Kumasi-Ashanti region) two days after the questionnaire was administered to her. This was not foreseen as I was assured to receive the answered questionnaire three days after the day of administration. The data was imputed into the SPSS version 23 for analysis.

Reliability of Instrument

The reliability (internal consistency) of the questionnaire for the main study was estimated using Cronbach's co-efficient alpha. According to Cronbach (as cited in Ebel & Frisbie, 1991), "co-efficient alpha can provide a reliability estimate for a measure composed of items of varying point values such as essays or attitude scales that provide responses such as strongly agree and strongly disagree with intermediate response options". The Cronbachs' co-efficient alpha for the subscale and the entire scale is presented in the table below.

Table 2: Reliability Statistics of Data Collection Instrument

Scales	Cronbach's Alpha	N of items
B	0.81	20
C	0.70	30
D	0.78	38
E	0.71	7
Entire scale	0.73	95

Source: Field Survey, Owusu

Data Collection Procedures

Ethical clearance was obtained from institutional review board of university of cape coast (UCC) (Appendix B). The letter was sent to seek an approval from the ethics committee of the Hospital (CCTH) involved in the study. The letter spelt out the purposes of the study, the need for individual participation and anonymity as well as confidentiality of respondents' responses. After establishing the necessary contact with nurses, permission was sought from the various in-charges of departments for the administration of the instrument. The questionnaire was administered personally by me, assisted by field assistants to all the 230 nurses whose number was selected randomly during the sampling procedure after consent of respondent had been sought. The questionnaire was distributed to nurses. A period of one week was used to administer the questionnaire. Respondents were given a period of ten working days to respond to the questionnaire after which I went back to collect the instrument.

The data collection process started on 28th May, 2018 and ended on 8th June, 2018. It should be noted that I made about four follow-ups to many of the respondents before completed questionnaires were fully collected. Respondents who refused to participate in the study were educated on the necessity and importance of research in nursing practice. Despite the effort made to encourage respondents to contribute to academic work, some accepted to participate whilst others did not. Hence, out of 230 questionnaires administered, 215 representing 93.5% of total respondents were retrieved. The 15 (6.5%) non-retrieved administered questionnaire was subject to the unwillingness of some respondents to contribute to the academic work.

Data Processing and Analysis

The responses to the questionnaires were first edited, coded and scored. The editing procedure was to check whether respondents had followed directions correctly, and whether all items had been responded to. The Statistical Package for Social Science (SPSS version 23.0) was used for the analysis. Section A on the questionnaire was on some demographic data of the respondents (See Table 3). Frequencies and percentages were used to describe the socio-demographic characteristics of respondents.

The questionnaire was coded and scored by assigning numbers to the responses. For Section B, items were assigned the weights of 3, 2, and 1 for “Don’t know”, “False and True” options/responses respectively. For Section C, Items were assigned the weights of 5, 4, 3, 2, and 1 for “Strongly Disagree”, “Disagree”, “Uncertain”, “Agree” and “Strongly Agree” respectively. Items in Section D, were assigned the weights of 1 and 2 for “No” and “Yes” options. For Section E, items were assigned the weights of 1 and 2 for “No” and “Yes” options. With respect to the specific research questions, the following statistical tools were used to analyse the data collected to answer them.

Research Question One

What is the knowledge level, attitude and practice of PC among nurses at CCTH?

Descriptive and inferential statistics were used in analysing the results of the study. Frequencies, means and percentages were used to describe the variable – knowledge of nurses, with outcome variable of “True”, “False” and “Don’t Know”. With respect to attitude of nurses, the outcome variable consists of five-point Likert scale; “Strongly Disagree”, “Disagree”, “Uncertain”, “Agree”, and “Strongly Agree”. One sample t-test was used to determine statistical difference between the sample mean and the sample midpoint of the test variable (attitude). One sample t-test was used to ascertain whether the sample mean is statistically different from a known difference in mean. The Practices of PC had two outcome variables, “Yes” and “No.” This was analysed using frequencies and percentages. This helped to ascertain whether or not nurse at CCTH practice PC.

Research Question Two

Regarding the research question; what is the influence of respondents' age, qualification and working experience on the practices of PC at CCTH? A hierarchical regression analysis was used to determine if any of the independent variable - socio-demographic variable (age, qualification and working experience) will be able to predict the dependent variable - practice of PC among nurses at CCTH. Hierarchical regression is mostly used to show if variables of interest explain a statistically significant amount of variance in the Dependent Variable (DV) after accounting for all other variables (Saunders et al., 2009).

Research Question Three

Pearson product moment correlation coefficient (r) was used to determine the strength of the relationship between knowledge and practice and between knowledge and attitude of PC among nurses at CCTH to answer the research question; what is the relationship between knowledge level and practice; knowledge and attitude of PC among nurses at CCTH

Research Question Four

The aim of this research question was to determine what nurses at CCTH perceived as barriers in PC practice. The barriers to PC practices had two main outcome variable "Yes" and "No." this was analysed using frequencies and percentages.

Chapter Summary

This Chapter focused on methods that underpinned this study. The key areas discussed in this Chapter were research design specifically quantitative approach (descriptive cross-sectional design). The study employed the use of Slovins’ formula to determine a sample size of 230 respondents for the study. Other issues discussed were the use of palliative care quiz for nursing (PCQN) and Frommelt Attitudes toward Care of the Dying (FATCOD) Scale for assessing data on knowledge and attitude of nurses towards PC. The methods of analysis, which were mainly descriptive statistics (frequencies, means, percentages and standard deviation) as well as inferential statistics (One sample t-test, hierarchical regression and Pearson product moment correlation coefficient) techniques applied to the data have also been highlighted in the Chapter. More so, the chapter revealed that, by using a cross-sectional data for this study, there is no attempts to offer any causal linkages as a limitation of the study design. Hence, the results only reflect associations and these should be borne in mind in interpreting the results. Analysis of findings are discussed in detail in chapter four.

CHAPTER FOUR

RESULTS AND DISCUSSION

Introduction

This chapter presents data collected from the field analysis, presentations and interpretations of the findings of the study. The chapter is divided into two sections. The first contains data collected on nurses (respondents) using questionnaire which includes their biological data. The second section presents their responses to the questionnaire pertaining to the research under study as well as discussions of the results and answering of research questions.

Demographic Information of the Respondents

This section gives the background information on the respondents. It covers respondents' information on sex, age, and care length for the terminally ill patient, work experience, ward of work of the respondent, educational level of the respondent and ethnicity of the respondent. The study was carried out at the Cape Coast Teaching Hospital in the Central Region of Ghana, with a sample size of 215. Table 3 presents the demographic information distribution of respondents involved in the study.

Table 3: Distribution of Participants by Demographic Data

Variables	**Frequency (n)**	**Percentage (%)**
Gender		
Male	94	43.7
Female	211	56.3
Total	**215**	**100.0**

Table 3 continued

Age		
20-29	162	75.3
30-39	46	21.4
40 and above	7	3.3
Total	**215**	**100.0**
Ethnicity		
Asante	145	67.4
Fante	40	18.6
Ga	12	5.6
Ewe	13	6.0
Others	5	2.3
Total	**215**	**100.0**
Qualification		
Certificate	4	1.9
Diploma	27	12.6
Degree	184	85.6
Total	**215**	**100.0**
Ward of work		
Medical unit	125	58.1
Surgical unit	40	18.6
Paediatric unit	12	5.6
Emergency unit	16	7.4
Intensive care unit	22	10.2
Total	**215**	**100.0**
Years of working experience		
1-5	170	79.1
6-10	25	11.6
Above 10	20	9.3
Total	**215**	**100.0**
Care length for terminally ill patients		
Days	94	43.7
Weeks	70	32.6
Months	51	23.7

Table 3 continued

Total	**215**	**100.0**
Do you have any training on palliative care?		
Yes	109	50.7
No	106	49.3
Total	**215**	**100.0**
How long did the training take?		
Days	68	62.4
Weeks	9	8.3
Months	32	29.3
Total	**109**	**100.0**

Source: Field Survey, Owusu (2018)

Table 3 shows that 43.7% of the respondents were male whilst 56.3% were females. It was found that 75.3% were between 20 to 29 years whilst 3.3% were 40 years and above. Asante's ethnic group constituted the majority of respondents (57.2%), with other tribes (2.3%) recording the least among the respondents. A greater number of the respondent (85.6%) holds a Degree in nursing with 12.6 percent of respondents having a Diploma. However, there are few of the respondents (1.9%) having a certificate. More so, majority 170 (79.5%) of the respondents have 1-5 years of working experience. Respondents with above 10 years working experience constituted least 20(9.3%). In addition, those who care for terminally ill patient daily recorded 94 (43.7%) whiles those having training on PC were 50.7%. More so, majority (58.1%) of the respondents work at the medical unit with few (5.6%) working at the paediatric unit.

Research Question One

What is the Knowledge Level, Attitude and Practice of PC among Nurses at CCTH?

The main aim of this research question was to determine whether or not nurses at CCTH have knowledge, ascertain their attitude and practice towards palliative care.

To ascertain the knowledge level of respondents, a quiz consisting of twenty close ended items were presented for the respondent to indicate whether the items are 'true', 'false', or don't know' to determine nurses' knowledge level. Overall, the sample mean score was 17.4 with a standard deviation of 0.91. The most frequent score was 16 out of 20 points (n=70, 32.6%). Other frequent scores were 19 (n=60, 27.9%) and 20 (n=40, 18.6%). These scores signify that nurses at CCTH are scoring above average on this quiz, indicating a good level of PC knowledge.

The following table is the PCQN broken down per question with the frequency and percentage of students who answered correctly and incorrectly.

Table 4: Palliative Care Quiz for Nursing Frequency and Percentage of Correct and Incorrect Response

PCQN Questions with Correct Answers *T*=True *F*=False	Correct		Incorrect	
	n	%	*n*	%
1. Palliative care is appropriate only in situations where there is evidence of a downhill deterioration. *F*	118	54.9	97	45.1
2. Morphine is the standard used to compare the analgesic effect of other opioids. *T*	171	79.5	44	20.5
3. The extent of the disease determines the method of pain treatment. *F*	169	88.5	22	11.5
4. Adjuvant therapies are important in managing pain. *T*	167	77.7	48	22.3

Table 4 Continued

5. It is essential for family members to remain at the bedside until death occurs. *F*	144	66.9	71	33.1
6. During the last days of life, the drowsiness associated with electrolyte imbalance may decrease he need for sedation. *T*	133	61.9	82	38.1
7. Drug addiction is a major problem when morphine is used on a long-term basis for the management of pain. *F*	88	40.9	127	59.1
8. Individuals who are taking opioids should also follow a bowel regime. *T*	122	56.7	93	43.3
9. The provision of palliative care requires emotional detachment. *F*	93	43.3	122	56.7
10. During the terminal stages of an illness, drugs that can cause respiratory depression are appropriate for the treatment for severe dyspnoea. *T*	133	61.9	82	38.1
11. Men generally reconcile their grief more quickly than women. *F*	108	50.2	107	49.8
12. The philosophy of palliative care is compatible with that of aggressive treatment. *T*	45	20.9	170	79.1
13. The use of placebos is appropriate in the treatment of some types of pain. *F*	45	20.9	170	79.1
14. In high doses, codeine causes more nausea and vomiting than morphine. *T*	134	62.3	81	37.7
15. Suffering and physical pain are synonymous. *F*	77	35.8	138	64.2
16. Demerol is not an effective analgesic in the control of chronic pain. *T*	86	40	129	60
17. The accumulation of losses renders burnout unavoidable for those who seek work in palliative care. *F*	80	37.2	135	62.8
18. Manifestations of chronic pain are different from those of acute pain. *T*	162	75.3	53	24.6
19. The loss of a distant or quarrelsome relationship is easier to resolve than the loss of one that is close or intimate. *F*	86	40	129	60
20. The pain threshold is lowered by anxiety or fatigue. *T*	95	44.2	120	55.8

Source: Field Survey, Owusu (2018).

From Table 4, areas with high percentages of correct responses were related to management and control of pain. Majority 171 (79.5%) of the respondents indicated that the item "Morphine is the standard used to compare the analgesic effect of other opioids" whiles 44 (20.5%) answered incorrectly and "During the last days of life, the drowsiness associated with electrolyte imbalance may decrease the need for sedation" 133 (61.9%). This indicates that, nurses at CCTH have good level of knowledge in PC especially with drug therapy for terminally ill patients. In the aspect of psychological issues in PC, majority of nurses exhibited adequate knowledge. For instance, 144(66.9%) of the respondents representing the majority indicated the item "It is crucial for family members to remain at the bedside until death occurs" correctly. Again, majority 105(50.2%) of the respondents answered correctly "Men generally reconcile their grief more quickly than women." Therefore, it can be concluded that majority of the nurses at CCTH had knowledge on PC.

However, nurses at CCTH did not show knowledge in the aspect of the use of placebo in managing chronic and terminally ill patient. As a result, majority 170 (79.1%) of the nurses indicated that the use of placebos is appropriate in the treatment of some types of pain which is false.

Respondent's attitude towards Palliative Care

The responses of participants were obtained using thirty (30) statements and the activities were on a five-point Likert type scale as, 'Strongly disagree' (1), 'Disagree' (2), 'Undecided' (3), 'Agree' (4) and 'Strongly agree' (5). The scale was summed up to form three-point scale; Agree' and 'Strongly agree' = (Agree), undecided and 'Strongly disagree' and 'Disagree' = (Disagree) to aid in the analysis. The cut-off point for the scale was calculated by summing the weight of the responses and dividing by the number of responses giving the cut-off point value (3.0)

Table 5: One Sample t-Test of Respondents Attitudes towards Palliative Care (n=215)

Statement	M	SD	t-value	df	p-value
1. Care to the dying person is a worthy experience.	3.87	1.29	9.820	214	<0.001
2. Death is not the worst thing that can happen to a person.	2.87	1.53	-1.287	214	.199
3. I would be uncomfortable talking about impending death with the dying person.	3.80	5.17	2.282	214	.023*
4. Caring for the patient's family should continue throughout the period of grief and bereavement.	3.89	1.27	10.290	214	<0.001
5. I would not want to care for a dying person	1.85	1.17	-14.432	214	<0.001
6. The non-family caregivers should not be the one to talk about death with the dying person.	3.29	3.14	1.325	214	.187
7. The length of time required to give care to a dying person would frustrate me	2.00	1.09	-13.318	214	<0.001
8. It is difficult to form a close relationship with the dying person.	2.73	1.34	-2.985	214	.003*
9. There are times when death is welcomed by the dying person	2.70	1.31	-3.334	214	.001*
10. When a patient asks, "Am I dying?" I think it is best to change the subject to something cheerful.	4.58	6.15	3.755	214	<0.001
11. The family should be involved in the physical care of the dying person.	3.84	5.15	2.393	214	.018*

Table 5 Continued

12. I would hope the person I'm caring for dies when I am not present	3.77	1.39	8.118	214	<0.001
13. I am afraid to become friends with a dying person.	3.44	4.77	1.343	214	.181
14. I would feel like running away when the person actually died	1.93	1.08	-14.377	214	<0.001
15. Families need emotional support to accept the behaviour changes of the dying person.	2.11	1.33	-9.820	214	<0.001
16. As a patient nears death, the non-family caregiver should withdraw from his or her involvement with the patient.	3.80	1.33	8.717	214	<0.001
17. Families should be concerned about helping their dying member make the best of his or her remaining life.	2.31	1.29	-7.781	214	<0.001
18. The dying person should not be allowed to make decisions about his or her physical care.	3.66	1.35	7.067	214	<0.001
19. Families should maintain as normal an environment as possible for their dying member.	2.37	1.41	-6.543	214	<0.001
20. It is beneficial for the dying person to verbalize his or her feelings.	3.46	1.37	4.905	214	<0.001
21. Care should extend to the family of the dying person.	4.34	4.89	4.028	214	<0.001
22. Caregivers should permit dying persons to have flexible visiting schedules.	3.70	1.18	8.600	214	<0.001

Table 5 Continued

23. The dying person and his or her family should be the in-charge decision makers.	3.49	1.32	5.441	214	<0.001
24. Addiction to pain relieving medication should not be a concern when dealing with a dying person.	3.00	1.37	-.049	214	.961
25. I would be uncomfortable if I entered the room of a terminally ill person and found him or her crying.	3.25	1.23	2.929	214	.004*
26. Dying persons should be given honest answers about their condition	3.06	1.37	.644	214	.521
27. Educating families about death and dying is not a non-family caregiver’s responsibility.	3.59	1.21	7.151	214	<0.001
28. Family members who stay close to a dying person often interfere with the professional’s job with the patient.	3.46	3.79	1.781	214	.076
29. It is possible for non-family caregivers to help patients prepare for death.	2.99	1.32	-.103	214	.918
30. Families should be concerned about helping their dying member make the best of his or her remaining life.	3.25	1.33	2.755	214	.006*

Source: Field Survey, Owusu (2018)

From Table 5, the one sample t-test result indicates that respondents have favourable attitudes towards palliative care. The test indicated significant results. These include: (1) Care to the dying person is a worthwhile experience. (M = 3.87, SD =1.29, t (214) = 9.820, P < .001, 2-tailed), (2) Caregivers should permit dying persons to have flexible visiting schedules. (M = 3.70, SD = 1.18, t (214) =8.600, p < .001), (3) The dying person and his or her family should be the in-charge decision makers. (M = 3.49, SD = 1.32, t (214) =5.441, P < .001) (4) Caring for the patient's family should continue throughout the period of grief and bereavement (M = 3.89, SD =1.27, t (214) =10.290, p < .001, 2-tailed), (5) When a patient asks, "Am I dying?" I think it is best to change the subject to something cheerful (MD = 4.58, SD = 6.15, t (214) = 3.755, p < .001, 2-tailed), (6) I would hope the person I'm caring for dies when I am not present (MD = 3.77, SD =1.39, t (214) = 8.118, p < .001, 2-tailed) and (7) As a patient nears death, the non-family caregiver should withdraw from his or her involvement with the patient (MD = 3.80, SD =1.33, t (214) = 8.717, p < .001, 2-tailed). This is an indication that nurses at CCTH have a favourable attitude toward patients.

Respondents Practice of palliative care

The PC practices among nurses in CCTH were also examined. Eleven major close ended items all geared towards examining the practices of PC among nurses were presented for the respondents to indicate 'yes' or 'No'. The responses were analysed with frequencies and percentages which is presented in the table below.

Table 6: Distribution of Results of Respondents Practices of Palliative Care

Palliative Care Practice	YES		NO	
	Freq	%	Freq	%
Initiate palliative care discussion				
During diagnosis	174	80.9	41	19.1
When the disease progress	180	83.7	35	16.3
At the end of life	144	67.0	71	33.0
Factors considered when dealing with terminally ill patient				
Spiritual	181	84.2	34	15.8
Medical situation	191	88.9	24	11.1
Cultural	170	79.1	45	20.9
Psychological	204	94.9	11	5.1
How do you address patient's spiritual issues?				
Connect with spiritual counsellor	196	91.2	19	8.8
Listen with empathy	194	90.2	21	9.8
Impose your own view	58	27.0	157	73.0
Understand patient reaction	187	87.0	28	13.0
What should Cultural assessment during patient care include?				
Truth telling and decision making	204	94.9	11	5.1
Preference regarding disclosure of information	181	84.2	34	15.8
Dietary preference	187	87.0	28	13.0
Language, family communication	197	91.6	18	8.4
Perspective on death, suffering & grieving	177	82.3	38	17.7
How do you address patient's psychological issue				
Emotional support	202	94.0	13	6.0
Counselling the patient	197	91.6	18	8.4
Hiding the truth	77	35.8	138	64.2

Table 6 Continued

Whom do you involve in decision making?				
Patient	197	91.6	18	8.4
Family	188	87.4	27	12.6
My own	119	55.3	96	44.7
Other health professional	180	83.7	35	16.3
How do you perceive terminally ill patient concern or question?				
Patient right	197	91.6	18	8.4
Treat.	168	78.1	47	21.9
Doubting your professionalism	72	33.5	141	65.6
Attention seeking behaviour	103	47.9	112	52.1
Communication to the family of terminally ill patient depends on:				
Family's ability to assimilate	184	85.6	31	14.4
Table 6 cont'd Their involvement in decision making	187	87.0	28	13.0
Your willingness to disclose information	125	58.1	90	41.9
Commonly use medication in your practice for severe pain?				
Paracetamol/Ibuprofin	137	63.7	78	36.3
Codeine	115	53.5	100	46.5
Morphine	185	86.0	30	14.0
How do you assess patient pain?				
Grade with face	192	89.3	23	10.7
Intensity	192	89.3	23	10.7
Location	169	78.6	46	21.4
Quality	136	63.3	79	36.7

Source: Field Survey, Owusu (2018)

As shown in Table 5, the results presented indicate nurses provide care to terminally ill patients based on the basic concepts in PC. For instance, the results indicate that, majority 196 (91.2) addresses the spiritual issues of terminally ill patients by connecting them with their spiritual counsellors whiles 19(8.8) think otherwise. In terms of nurses addressing psychological issues, majority 202 (94.0%) of the respondents indicated 'yes' for considering "emotional support" while the remaining 13 (6.0%) think otherwise.

Regarding how nurses at CCTH perceive terminally ill patients concern and questions majority 197 (91.6%) of respondents indicated 'yes' to the item "patient rights" and 18 (8.0%) indicated 'no.' With reference to nurses commonly used medication in their practice of severe pain, majority 185 (87%) of the respondent indicated 'yes' they use "Morphine" while only 30 (14%) indicated 'no' to the item. For "Codeine", 115(53.5%) of the respondents affirmed they commonly used it in their practice of severe pain. In conclusion, for the commonly use medication among nurses in their practice of severe pain, Morphine comes first, followed by Paracetamol or Ibuprofin and finally, codeine. This means nurses at CCTH practice PC with regards to pain management. In conclusion, the study revealed that, to a great extent nurses at CCTH practice palliative and end-of-life care.

Research Question Two

What is the Influence of Respondent's Age, Qualification and Working Experience on the Practices of PC at CCTH?

The purpose of this research question was to find out whether age, qualification and working experience of respondents could predict the practices of palliative care at the Cape Coast Teaching Hospital in the Central Region of

Ghana. Hierarchical regression analysis was computed and the result is presented in Table 7.

Table 7: Analysis of Results of Predictors of Practices of Palliative Care

Model	Unstandardized Coefficients		Standardized Coefficients	t	p-value
	Beta	Std. Error	Beta		
(Constant)	44.727	2.587		17.290	0.000
Age	0.719	0.752	0.071	0.956	0.340
Qualification	0.663	0.852	0.054	0.779	0.437
Working experience	-0.683	0.605	-0.083	-1.129	0.260

Dependent Variable: Practice of Palliative Care

Table 7 presents the coefficients model for demographic factors (age, qualification and working experience) and how they predicted practice of palliative care. It can be seen from Table 5 that all the three demographic factors (independent variables) are not statistically significance at 0.05 level of significance. Age (p-value = 0.340), qualification (p-value = 0.437) and working experience (p-value =0 .260). When evaluating the standardized beta values, (correlation) among the predictors, it was revealed that the age had (Beta=0.071), qualification (Beta=0.054) and working experience (Beta= -0.083). The results therefore revealed that none of the predictor variables predicted the practices of palliative care.

Research Question Three

What is the Relationship between Knowledge Level and Practice and between Knowledge and Attitude of PC among Nurses at CCTH?

Research question three determined the relationship between knowledge level and practice of palliative care among nurses at the Cape Coast Teaching Hospital. The Pearson product moment correlation was performed and the result is presented in Table 8.

Table 8: Pearson Product Moment Correlations of Knowledge and Practices of Palliative Care

		Knowledge	Practice
Knowledge	Pearson Correlation	1	0.146
	Sig. (2-tailed)		0.041
	N	215	215
Practice	Pearson Correlation	0.146^*	1
	Sig. (2-tailed)	0.041	
	N	215	215

Correlation is significant at the 0.05 level (2-tailed)

From Table 8, it was found that low positive relationship exists between knowledge and practices of palliative care. The result further showed a significant relationship between knowledge and practice of palliative care, r = 0.146, p = 0.041. This implies that respondents with knowledge of palliative care will tend to practice palliative care.

The relationship between knowledge level and attitude of nurses towards practice of palliative care was also determined. The Pearson product moment correlation was performed and the result is presented in Table 9.

Table 9: Pearson Product Moment Correlations of Knowledge and Attitude towards the Practices of Palliative Care

		Knowledge	Attitude
Knowledge	Pearson Correlation	1	0.313
	Sig. (2-tailed)		< 0.001
	N	215	215
Attitude	Pearson Correlation	0.313	1
	Sig. (2-tailed)	< 0.001	
	N	215	215

Correlation is significant at the 0.01 level (2-tailed)

Nurses' level of palliative knowledge may influence their attitude towards palliative patients. As depicted in Table 9, there is a low positive relationship between knowledge and nurses' attitudes towards the practices of palliative care. The result also revealed a significant relationship between knowledge and attitudes towards the practice of palliative care, $r = 0.313$, $p < 0.001$. Thus, as their knowledge level increases, the positive attitudes also increase ($r = 0.313$). This implies that respondents with knowledge of palliative care will tend to have positive attitude towards the practice of palliative care.

Research Question Four

What are the Barriers to PC among Nurses at CCTH?

The main aim of this research question was to assess what nurses at CCTH perceive as barriers to palliative care (PC) practices. Accordingly, seven key factors were presented for the respondents to indicate whether these factors are the barriers by indicating 'yes' or 'no'. Their responses were analysed using frequencies and percentage. This is presented in the table below.

Table 10: Distribution of Results of Barriers to Palliative Care Practices

Barriers	**YES**		**NO**	
	Freq	**%**	**Freq**	**%**
1. Poor funding	112	52.1	103	47.9
2. Restrictions on opioid availability	72	33.5	143	66.5
3. Negative attitudes of healthcare professionals	85	39.5	130	60.5
4. Low levels of public awareness	94	43.7	121	56.3
5. Inadequate education	110	51.2	105	48.8
6. Absence of curriculum content related to palliative care	78	36.3	137	63.7
7. Stress in caring for terminally ill patient	45	20.9	170	79.1

Source: Field Survey, Owusu (2018)

As depicted in Table 10, majority 112(52.1%) of the respondents affirmed that “poor funding” is a barrier to PC practices in the CCTH while 103(47.9%) think otherwise. If the views of the majority counts, then it is that the poor funding is barrier to PC care at CCTH. More so, majority 110(51.2) of the respondent indicated that “inadequate education” is a barrier to PC at the CCTH but think otherwise.

Besides, 177(82.3%) alluded to the fact that “stress in caring for terminally ill patient” is not a barrier to PC at the CCTH but 38(17.7%) of them indicated ‘no’ to the item. What this might mean is that nurses at CCTH do not see stress in caring for terminally ill patient at a barrier to PC. With a factor like “Restrictions on opioid availability”, majority 143(66.5%) of the respondents indicated ‘no’ while minority 72(33.5%) of the respondents indicated ‘yes’. It is likely that restrictions on opioid availability is not a barrier to PC at CCTH as majority of the respondent in the study alluded.

In conclusion, nurses at the CCTH perceive poor funding and inadequate education as the major barriers to PC at the CCTH. The study however, revealed that, the strategies that could be adopted to reduce these barriers to palliative care practices at CCTH include; granting scholarship to nurses to further education, in-service training on PC, and establishing a PC specialised unit to provide PC services to terminally ill patients.

Discussion of Research Findings

In this section, the findings are discussed in relation to:

1. Nurses knowledge, attitude and practice to PC
2. Relationship between Knowledge, Attitude and Practice of Palliative and End-of-Care among Nurses
3. Barriers to PC practices as perceived by nurses at CCTH

Nurses knowledge, attitude and practice of PC

The findings of the study indicated that, nurses at CCTH have knowledge in PC with respondents having a mean score of 17.4 (SD = 0.91) indicating a good performance in the PCQN, a reflection of the nurses having adequate knowledge in palliative care. The possible reason for this might be that these nurses have been trained on palliative care on the job. This could have also been that, majority 184 (85.6%) of the participant were having degree and might have had some sought of training on PC in school. A study in Australia showed that training on PC was the most frequently nominated professional need among nurses (Redman et al., 1995). Similarly, a study by conducted Pan et al. (2017) in Taiwan, indicated a there is good palliative care services at haematology and oncology ward with higher level of knowledge (M = 16.5, SD = 2.3). The study also indicated that, majority of the respondents were having a bachelors' degree and had had in-service training on PC.

However, most of the studies conducted on PC indicated that nurses have moderate knowledge on PC. According to Brajtman et al. (2009) performed a study examining PC knowledge among Canadian nurses which resulted in an average score of 61% (M = 12.29) indicating a moderate knowledge level. Similarly, Knapp el at. (2009) in their study indicated that Paediatric nursing workers in Florida have a moderate level of baseline knowledge regarding palliative care with a mean of 10.9 (SD = 3.7). Other researchers found similar results in their findings. The findings of Kim et al. (2011), Storey and Ziemba-Davis (2013) and Kassa et al. (2014) support this current studies' finding that nurses have moderate knowledge of palliative care. Ronaldson et al., (2008) and Al Qadire (2014) in their studies reached similar conclusion that nurses have a moderate knowledge on palliative care.

Nevertheless, mention should be made of the fact that the finding of this current study was inconsistent with that of Sarfo et al. (2016) in a study conducted at Agogo Presbyterian Hospital in the Ashanti region of Ghana. The study revealed that, nurses have knowledge deficiencies in palliative care which had significantly translated into poor quality service among nurses in the hospital. This is also evident in Choi et al. (2012) findings, in a descriptive survey they which indicated that nurses had a low knowledge on PC. The mean score on the

PCQN was 8.94 (SD = 2.34) of a possible 20. The low level of nurses' knowledge about palliative care in these studies could be associated with the lack of specific palliative care units and lack of updating information regarding palliative care, and this might be due to the fact that PC education was not incorporated into in-service trainings in the hospital.

The study also sought to assess the attitude of nurses toward PC. The findings of this current study revealed that, nurses at CCTH have favourable attitudes towards palliative care. It can be deduced from the study that having knowledge in PC may reflect on the perception the nurse has toward PC. Other factors such as having training on PC and the conception (cultural beliefs) the nurses have regarding the dying patient may have contributed to the nurses at CCTH having favourable attitude toward PC. According to Ekore and Lanre-Abass (2016), in Africa, death is considered as a rite of passage and an individual will prefer a slow and lingering death that comes naturally as they will be able to tidy up many issues such as making peace and saying farewell to relatives hence caring for such people needs considerable care.

The study is consistent with the findings of Román et al. (2001). According to Román et al., nurses have favourable attitude regarding caring for dying patients. In support of this, Dunn et al. (2005) showed in their findings that, nurses show positive attitude towards caring for terminal patients. Similarly, in a cross-sectional descriptive study by Pan et al. (2017), it was observed that respondents have a favourable nursing attitude towards palliative care services. These findings were further confirmed in a cross-sectional qualitative study conducted by Kassa et al. (2014) which pinpointed that 76% of the respondents had favourable attitude towards palliative care. This argument was also supported by Iranmanesh et al. (2008). Mastroianni et al. (2015), Harding and Higginson (2004) and Das and Haseena (2015) also conducted similar studies which have direct consistency with the findings of this current study. These studies revealed that the educational level, conception of end of life care, type of health facility in which a nurse works and the social status of patients may have affected the attitudes nurses towards dying patients.

However, the findings of this current study is inconsistent with that of a descriptive cross-sectional survey study by Leclerc et al. (2014) which indicated that a greater percentage of overall nurses have unfavourable attitude regarding terminally ill care. According to Leclerc et al., death is a taboo subject in Quebic society. Workers need to demonstrate empathy with their residents, be compassionate, and be willing to take the risk of personal involvement. This can be inferred that inadequate education on PC, misconception and cultural beliefs about the dying contributed to the nurses having unfavourable attitude toward end of life care.

Their argument was in line with Banu and Sultan (2013) which was conducted at two University hospitals and one State hospital in Turkey. The argument is also supported in a cross-sectional study by Razban et al. (2013). The study stated that respondents have unfavourable attitude toward palliative care while in a study by Román et al. (2001) also emphasized that nurses, generically, have unfavourable pattern in attitudes regarding caring for dying patient.

Lastly, the current study revealed that, nurses at CCTH have adequate palliative and end-life-care practices. Adequate practice in this finding could be related with respondents' good knowledge and favourable attitude towards PC and it might also be due to the study subjects who had about five years of work experience and with degree qualification since experience and education might affect the practice. Likewise, Sorifa and Mosphea (2015), revealed that 91% of respondent have adequate practice regarding palliative care. Besides, a study by Jünger et al. (2010) revealed that general paediatric nurses had high desire to engross in palliative care, and also regarded palliative care as an aspect of their profile.

The findings in this current study indicates that nurses at CCTH provide care to terminally ill patients based on the basic concepts in PC. For instance, it was revealed that, the nurses address the spiritual issues of terminally ill patients by connecting them with their spiritual counsellors. In terms of nurses addressing psychological issues, they provide emotional support to patients. They also take into consideration the patients' concerns and questions as well as involving family in decision making which is a good practice in caring for a terminally ill or a dying patient.

Similarly, a study conducted by Latour et al. (2009), revealed that 78·6% of nurses shown their allegiance of involving family members in end of life decisions. These findings are in support with that of Kassa et al. (2014) which shows that, almost half of the informants reported that the diagnosis of patients was usually performed at the terminal stage by taken in to account the spiritual and medical conditions of the terminally ill patient. Pan et al. (2017), also indicated a better palliative care services of nurses at haematology and oncology ward.

More so, pain management seems to be one of the commonness practices among nurses. The findings in this current study showed that majority 185(86.0) nurses at CCTH manage patients pain using morphine which is a standard drug used in PC. This is in support of a study conducted by Puntillo et al. (2014) which identified opioids (Morphine) as the mainstay for pain management in PC. Puntillo et al. (2001) also revealed that almost every respondent in their study supported pain management and withholding, or withdrawing life support as favourable practice for unavoidable death. Latour et al. (2009) also supported this assertion by revealing in their study that, 98.8% of nurses in Europe show their willingness to provide continuous pain relief. Iranmanesh et al. (2014) also indicated that the highest correct response was demonstrated by management of pain and other symptoms, which represents 46.07% of the entire response rate. Health caregivers use different drugs in their attempt to manage pain.

It has been demonstrated that the attitudes toward death and toward caring for dying patients may influence the behaviour of nurses as well as the quality of care that they administer. The results suggest that attitudes are not only associated with the amount of time spent in close proximity with dying patients but also the conception (cultural beliefs) and the educational status of workers have impact on end of life care. Maybe the professional status and membership in a professional corporation offers more opportunities for continuing education, lectures, case discussions and a wide range of professional activities that contribute to professional growth.

Relationship between Knowledge, Attitude and Practice of Palliative and End-of-Care among Nurses

The findings of this current study revealed that, demographic features such as age, educational qualification and working experience do not have any influence on PC practice. However, the findings of Ayed et al. (2015) in a study revealed that 20.8% of the total respondent rate had good knowledge and practice palliative care and that 59.4% of these respondents had training on palliative care. This explicitly indicates that fewer of the respondents were given palliative care training and hence the lower or decrease practice among nurses. A descriptive study by Choi et al. (2012) also identified that there was a statistically significant difference between respondents exposed to end-of-life care education and those without.

From the study, it is seen that, having knowledge in PC may tend to lead one to practice PC. The study showed a low positive correlation between Knowledge and practice ($r = 0.146$, $p = 0.041$). Meaza and Worku (2012) found in their study that there is a low positive correlation between knowledge and attitude regarding palliative care which is statistically significant ($r = 0.268$, $p < 0.001$). This is supported by a study conducted by Sorifa and Mosphea (2015) which shown that there is a direct relationship between knowledge and practice scores of palliative care among nurses, a correlation of ($r = 0.30$, $p < 0.001$). This indicates that the more nurses are educated on PC the higher the likelihood that they would practice PC.

Mention should also be made of the fact that the study revealed a low positive correlation which is statistically significant ($r = 0.41$, $p < 0.001$) between

Knowledge and attitude of nurses regarding PC. This is in line with a study conducted by Razban et al. (2013) which pinpointed a significant correlation between nursing staffs' attitudes regarding palliative care and palliative care education, personal study about palliative care, education level, and caring experience. Again, descriptive study by Das & Haseena (2015) also revealed a 0.272 ($p < 0.001$) correlation co-efficient value indicating a weak positive correlation between knowledge score and attitude score of staff nurses regarding palliative care. This implies that respondents with knowledge of palliative care will tend to have positive attitude towards the practice of palliative care as explicitly seen in the findings of this current study.

Barriers to PC as percieved by nurses at CCTH

The perceived barriers to PC by nurses at CCTH were poor funding and inadequate education on PC. The study showed that practicing nurses are of the view that inadequate funding of PC will not aid them to practice effectively. This implies that, nurses will not get the needed facilities to provide appropriate PC services. Coupled with the above, the study further revealed that inadequate education is a barrier to PC practices. This is to say that, inadequate education (low clinical training) may render nurses with insufficient knowledge incapable of applying basic principles of PC to practice.

According to a report by World Health Organization in 2005, lack of trained personnel, particularly health providers and social workers, lack of a multidisciplinary palliative care team, poor discernment regarding palliative care on the part of health providers, and shortage of hospices and day care centres pose challenges to palliative care activities.

Furthermore, this is in line with several authors (Granek et al., 2013; Born &Greiner, 2004; Jünger et al., 2010; Soyannwo et al., 2001; Harding & Higginson, 2004). The authors indicated that the key challenge of palliative care sustainability on the African continent includes lack of financial resources and inadequate education (low clinical training); and inadequate regulation on procurement of drugs Ajayi et al. (2015).

Moreover, the study revealed that, the strategies that could be adopted to reduce perceived barriers to palliative care practices at CCTH include; granting scholarship to nurses to further education, in-service training on PC, and establishing a PC specialised unit to provide PC services to terminally ill patients.

Chapter Summary

This chapter focused on the findings of the study with respect to background characteristics of respondents, knowledge, attitude and practice of PC among nurses at CCTH. The study used frequency counts and percentages, means and standard deviations; Correlations were used in the analysis. The results showed that the nurses at CCTH have a good knowledge in palliative care. Besides, nurses at CCTH had a favourable attitude towards palliative care. Again, the study found that nurses at CCTH to a great extent practice palliative care. The study also revealed a low positive correlation between knowledge and practice; and knowledge and attitude towards PC. Additionally, it was also discovered that nurses at CCTH perceived poor funding and inadequate education as a barrier to PC and end-of-life care.

CHAPTER FIVE

SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

Introduction

The study assessed the practices of palliative and end of life care among nurses at Cape Coast Teaching Hospital (CCTH). The study focused on the following specific objectives; assessed the knowledge level, attitude and practice of PC among nurses a CCTH palliative care at CCTH; to examine the influence of respondents age, qualification and working experience on the practices of PC at CCTH; to determine the relationship between knowledge level and practice of PC among nurses at CCTH and between knowledge level and attitude of PC among nurses at CCTH; and to determine the barriers to PC among nurses at CCTH This chapter captures the summary of findings that were made from the study. It goes on to provide conclusions made from the study and thereafter gave recommendations to various stakeholders in society based on the findings and conclusions. The chapter ends by giving directions for further research on the study.

Summary of Findings

The study largely assessed the practices of palliative and end of life care among nurses at Cape Coast Teaching Hospital (CCTH). The population for the study included 543 nurses in the CCTH. The study employed descriptive survey design and the main instrument used for the study was a questionnaire and randomly selected 215 respondents. The study used frequency counts and percentages, means and standard deviations, correlations.

The study found that the nurses at CCTH have a good knowledge in palliative care as majority of the respondents score greater than 70 percent. Thus, overall performance of the respondent on PC was impressive. The correctly answered items formed 65 percent of the total items hence an indication of good performance. Another key finding of this study was that nurses at CCTH had a favourable attitude towards palliative care.

Again, the study found that nurses at CCTH to a great extent practice palliative care. Thus, majority of the respondent initiate palliative care discussion during diagnosis and when the disease progress. Besides, nurses consider factors like medical situation, Psychological factors and spiritual factors when dealing with ill patients. The study revealed that, there was a low positive correlation ($r = .1466$) between nurses' knowledge and practice and between knowledge and attitude ($r = .313$). The study also discovered that nurses at CCTH perceived poor funding and inadequate education as the key barriers of palliative care practices at the CCTH.

Finally, the study found that the strategies that could be adopted to reduce perceived barriers to palliative care practices at CCTH include; Granting scholarship to nurses to further education, in-service training in PC, and establishing a PC specialised unit to provide PC services to terminally ill patients.

Conclusions

This study provided an insight into PC and end-of-life care by examining the Knowledge, attitude and practices of PC among Ghanaian nurses who work in broader clinical settings especially in Cape Coast Teaching Hospital. The key findings indicated that nurses at CCTH are knowledgeable in PC and have favourable attitude towards its practices. Findings also revealed that CCTH like many hospitals in West Africa has no PC specialty to honour effective and procedural PC practices as in support of Ajayi et al. (2015). However, despite the low service provision in Ghana, the current study revealed that, nurses at CCTH are able to apply the principles of PC to render care to terminally ill patients. This partly suggests that, inclusion of access to PC services into the main stream of health care is imperative.

The lack of PC specialty at CCTH could be elucidated that healthcare facilities in West Africa countries attach little importance to having PC specialty. More education on PC and end-of-care practices is, therefore, needed in this area to enable authorities of healthcare facilities in West African countries (especially Ghana) to ensure well established PC specialty units so as to provide the comfort needed by terminally ill or dying patients at the end-of-life. When patients have been given a terminal illness or diagnosis, patients begin to assume they will die miserably. Nurses, as key members in the healthcare setting ought to be the voice of the patient to the physician. There needs to be more obligatory education offered to practicing nurses in all the different types of healthcare settings.

Recommendations

Based on the findings of the study, the following recommendation are made

Nursing Management of CCTH

1. The use of placebo which is not a good practice in PC was appreciated by participants. Using placebo in managing a terminally ill patients' pain will not help alleviate their pain and might lead to patient discomfort. I therefore recommend that management at CCTH should encourage nurses at the hospital to always administer pain medication to patient when the need be. This will help promote patient comfort.
2. Although nurses had knowledge on PC, management of CCTH should organise timely in-service training in the form of workshops, symposiums and conferences on PC for nurses at the hospital. This will help nurses to be well-informed on contemporary issues on palliative and end-of-life care.
3. Nurses had favourable attitude toward the practice of PC. I recommend that management at CCTH should encourage nurses to continue to have positive attitude toward the practice of PC. This will also enable nurses to always be abreast with current issues pertaining to PC so that they can always apply it at the work place.
4. Management should place much emphasis on the establishment of PC specialty unit in the hospital to provide holistic end-of-life healthcare to terminally ill patient who requires PC services.

Policy

Ghana needs a holistic palliative healthcare policy. I recommend that government of Ghana and relevant agencies such as Ministry of Health and Ghana Health Service as well as management of CCTH should develop policies to improve PC services. To achieve that government should allocate more funds to the health sector in the country for PC services. Again, hospitals should be provided with PC specialty unit and adequate supply of equipment and drug needed in palliative and end-of-life care services.

Non-Governmental Organization

A key barrier to PC services at CCTH is inadequate funding of PC services as revealed in this current study. Therefore, I recommend that the Non-Governmental Organization (NGO) in the country should provide support to CCTH in this course. This will aid nurses at the hospital to provide palliative and end-of-life care effectively.

Suggestions for Further Studies

1. Future study should be done on the same subject taking into consideration terminally ill patients' satisfaction with PC services.
2. There is a need for a study that utilizes qualitative methods to explore the practices of palliative and end-of-life care among nurses.

REFERENCES

Abu-Saad, H. H., Dimassi, H. (2007). Palliative care in Lebanon: knowledge, attitudes and practices of physicians and nurses. *J Med Liban, 55*(3), 121-8.

Adamolekun, K. (1998). Openness of health professionals about death and terminal illness in a Nigerian teaching hospital. *Omega*, *36*, 23–32.

Ajayi, I., Iken, O., Powell, Richard, A., Soyannwo, O., Namisango, E., & Mwangi-powell, F. (2014). Palliative care research in western Africa. *European Journal of Palliative Care, 21*(1), 45–47.

Al Qadire, M. (2014). Knowledge of palliative care: An online survey. *Nurse education today, 34(*5), 714-718.

Amedahe, F. K. (2004). *Notes on educational research*. Unpublished manuscript.

Anteneh, S., Kassa, H., Demeke, T., & Guadu, D. (2016). Assessment of Nurses' Knowledge, Attitude, Pracctice and Associated Factors Towards Palliative Care: In the Case of Amhara Region Hospitals. *Advances in Biological Research*, *10*(12),110-123. https://doi.org/10.5829/idosi.abr.2016.10.2.10397

Arber, A. (2001). Student nurses' knowledge of palliative care: Evaluating an education module. *International Journal of Palliative Care*, *7*(12), 597-602.

Arfken, C. L. & Balon, B. (2011). Declining Participation in Research Studies. *Psychother Psychosom*, *80*, 325–328. DOI: 10.1159/000324795

Ayed, A., Sajei, S., Harazneh, L., Fashafsheh, I., & Eqtait, F. (2015). The Nurses Knowledge and Attitudes towards the Palliative Care. *Journal of Education andPractice*, *6*(4), 91–99.

Banu, C. & Sultan, K. (2013). Attitudes and Experiences of Nurses Toward Death and Caring for Dying Patients in Turkey. *European Journal of Oncology Nursing, 36* (6), 58-65. https://doi;10.1016/S1462-3889(10)70155-1.

Basal, A., & Youni, G. (2017). Critical Care Nurses' Knowledge, Practice, Obstacles and Helpful Measures Towards Palliative Care for Critically Ill Patients. *American Journal of Nursing Science, 6* (4), 293-303.

Becker, R. (2009). Palliative care: Principles of Palliative Care Nursing and End-of-Life Care. *Nursing Times, 105*, 13.

Beckstrand, R. L., & Kirchhoff, K. T. (2005). Providing end-of-life care to patients: Critical care nurses’ perceived obstacles and supportive behaviours. *American Journal of Critical Care, 14*, 395.

Born, W., & Greiner, K. (2004). Knowledge, attitudes, and beliefs about end of-life care among inner city African Americans and Latinos. *Journal of Palliative Medicine, 7*, 247-256.

Bradley, E. H., Cramer, L. D., Bogardus, S. T., Kasl, S.V., Johnson-Hurzeler, R. & Horwitz, S.M. (2002). Physicians’ Ratings of Their Knowledge, Attitudes, and End-of-life-care Practices. *Academic Medicine, 77*(4), 305-311.

Brajtman, S., Fothergill-Bourbonnais, F., Fiset, V., & Alain, D. (2009). Survey of educators' end-of-life care learning needs in a Canadian baccalaureate nursing programme. *International Journal of Palliative Nursing, 15*(5), 233-241.

Brazil, K., Brink, P., Kaasalainen, S., Kelly, M. L., & McAiney, C. (2012). Knowledge and perceived competence among nurses caring for the dying in long-term care homes. *International Journal of Palliative Nursing, 18*(2), 77-83.

Cape Coast Teaching Hospital [CCTH]. (2016). *About us.* Retrieved on December 08, 2018 from http:// http://www.ccthghana.org/

Cape Coast Teaching Hospital [CCTH] Health Informatics. (2018). *Nursing Population and Bed State.* Cape Coast, Ghana: Cape Coast Teaching Hospital

Choi, M.., Lee, J., sun Kim, S., Kim, D., & Kim, H. (2012). Nurses' Knowledge About End-of-Life Care: Where Are We?. *The Journal of Continuing Education in Nursing, 43*(8), 379-384.

Coelho, A., Parola, V., Escobar-bravo, M., & Apóstolo, J. (2016). Comfort experience in palliative care : a phenomenological study. *BMC Palliative Care, 15*(71), 1–8. https://doi.org/10.1186/s12904-016-0145-0

Cohen, L., Manion, K., & Morrison, L. (2007). *Research methods in education* (6th ed.). New York, NY: Routeledge Taylor & Francis Group.

Das, A. G., & Haseena, T. A. (2015). Knowledge and Attitude of Staff Nurses Regarding Palliative Care. *International Journal of Science and Research (IJSR), 4*(11), 1790-1794.

De-Vlieger, M., Gorchs, N., Lankin, P. J., & Porschet, F. (2004). Palliative nurse education towards a common language. *Palliative Medicine, 18* (5), 401-403.

De Vos, A. S., Strydom, H., Fouche, C. B., & Delport, C. S. L. (2011). *Research at Grass Root for the Social Sciences and Human Service Profession*. Pretoria, SA : Van Schalk Publishers.

Downing, T., Powell, R. A. & Mawangi-Powell, F. N. (2010). Home-Based Palliative Care in Sub-Saharan Africa. *Home Healthcare Nurse*, *28*(5), 2-10.

Dunn, K.S., Otten, C., & Stephens, E. (2005). Nursing experience and the care of dying patients. *Oncology Nursing Forum*, *32*(1), 97-104.

Ebel, L. R., & Frisbie, A. D. (1991). *Essentials of educational measuremen,* (5th ed.). Englewood Cliffs, New Jersey: Prentice Hall.

Egan, K. A. & Abbott, P. (2002). Interdisciplinary team training- preparing new employees for the specialty of hospice and palliative care. *Hosp Palliat Nurs*, *4*, 161-71.

Ekore, R. I. & Lanre-Abass, B. (2016) African Cultural Concept of death of Advance care Directives. Indian J Palliative Care, *22* (4), 369-372.

Fisher, C. (2007). *Researching and Writing a Dissertation: A Guidebook for Business Students.* Englewood Cliffs, NJ: Financial Times Prentice Hall Intervarsity Press.

Fraenkel, J. R., Wallen, N. E., & Hyun, H. H. (2012). *How to design and evaluate research in education.* (4th ed.). New York, NY: McGraw-Hill, Inc.

Frommelt, K. H. M. (1991). The effects of death education on nurses' attitudes toward caring for terminally ill persons and their families. *American Journal of Hospice and Palliative Medicine, 8*(5), 37-43.

Frommelt, K. H. M. (2003). Attitudes toward the care of terminally ill: An educational intervention. *American Journal of Hospice and Palliative Care, 20*, 13–19

Ghoche, R. (2012). Parkinsonism and Related Disorders The conceptual framework of palliative care applied to advanced Parkinson ' s disease. *Parkinsonism and Related Disorders*, *18*, S2–S5. https://doi.org/10.1016/j.parkreldis.2012.06.012

Granek, L., Krzyzanowska, M. K., Tozer, R., & Mazzotta, P. (2013). Oncologists' Strategies and Barriers to Effective Communication About the End of Life. *Journal of Oncology Practice*, *9*(4), 129-135. http://doi.org/10.1200/J OP.2012.000800

Grant, C., & Osanloo, A. (2014). Understanding, selecting, and integrating a theoretical framework in dissertation research: Creating the blueprint for your "house". *Administrative Issues Journal*, *4*(2), 4.

Hallenbeck, J. (2003). *Palliative care perspectives.* New York, NY: Oxford University Press.

Harding, R., & Higginson, I. J. (2004). *Palliative Care in Sub-Saharan Africa:* An Appraisal 2004.

Harding, R., & Higginson, I. J. (2005). Palliative care in sub-Saharan Africa. *The Lance*t, *365*(9475), 1971-1977.

Heide, A.V., Rietjens, J.A., Hauser, J., & Emanuel, L. (2007). Having a difficult time leaving: experiences and attitudes of nurses with palliative sedation, *Palliative Medicine, 21*, 643–649

Henn, M., Weinstein, M., & Foard, N. (2006). *A Short Introduction to Social Research.* London: SAGE Publication Ltd.

Hennekens, C. H. & Buring, J. E. (1987). *Epidermiology in Medicine*, Philadelphia, PA: Lippincott, Williams & Wilkins.

Hopkinson, J. B., Hallett, C. E., and Luker, K. A. (2005). Everyday death: how do nurses cope with caring for dying people in hospital? *International Journal of Nursing Studies, 42*, 125-133.

Hunt, J. (2008). *African Palliative Care Association Report for USAID*: *Palliative Care Assessment of Ten Pact Malawi Partner* Organisations. Unpublished Manuscript.

Institute of Medicine [IOM]. (2003). *When Children Die: Improving Palliative and End-of-Life Care for Children and Their Families.* Washington, DC: The National Academies Press. https://doi.org/10.17226/10390.

Iranmanesh, S., Dargahi, H., & Abbaszadeh, A. (2008). Attitudes of Iranian nurses toward caring for dying patients. *Palliative & supportive care, 6*(4), 363-369.

Iranmanesh, S., Razban, F., Tirgari, B., & Zahra, Z. (2014). Nurses’ knowledge about palliative care in Southeast Iran. *Palliative and Supportive Care, 12,* 203–210.

Israel, G. D. (1992). *Determing Sample Size* (PEOD Fact sheet No. 6). Gainesville, Florida: Florida Coorperatve Extension Service, University of Florida.

Joseph, N., Jayarama, S., & Kotian S. (2009). A comparative study to assess the awareness of palliative care between urban and rural areas of Ernakulum district, Kerala, India. *Indian J Palliat Care, 15*, 122-126. Available from: URL:http://www.jpalliativecare.com/text.asp?2009/ 15/2/122/58457

Jünger, S., Pastrana, T., Pestinger, M, Kern, M., Zernikow, B & Radbruch, L. (2010). Barriers and needs in paediatric palliative homecare in Germany: a qualitative interview study with professional experts. *BMC Palliative Care, 9*(10,) 2-11.

Kalogeropoulou, M., & Evanthia, P. D. (2016). Assessment of knowledge and associated factors towards PC among Greek nurses. *World journal of social science research, 3* (3), 381-395.

Karkada, S., Nayak, B. S., & Malathi. (2011). Awareness of Palliative Care Among Diploma nursing students. *Indian Journal of Palliative Care, 17*(1), 20-23. doi:10.4103/0973-1075.78445http://scihub.tw/http://www.jpalliativecare.com/text.asp?2011/17/1/20/78445

Kassa, H., Murugan, R., Zewdu1, F., Hailu, M., & Woldeyohannes, D. (2014). Assessment of knowledge, attitude and practice and associated factors towards palliative care among nurses working in selected hospitals, Addis Ababa, Ethiopia. *BMC Palliative Care, 13*(6), 1-11.

Kim, H. S., Kim, B. H., Yu, S. J., Kim, S., Park, S. H., Choi, S., et al (2011). The effect of an end-of-life nursing education consortium course on nurses' knowledge of hospice and palliative care in Korea. *Journal of Hospice & Palliative Nursing, 13*(4), 222-229

Knapp, C. A., Madden, V., Wang, H., Kassing, K., Curtis, C., Sloyer, P., & Shenkman, E. A. (2009). Paediatric nurses' knowledge of palliative care in Florida: A quantitative study. *International Journal of Palliative Nursing, 15*(9), 432-439.

Kolcaba, K., & Wilson, L. (2002). Comfort care: A framework for perianesthesia nursing. *Journal of PeriAnesthesia Nursing, 17*(2), 102-114.

Kolcaba, k. (2003). *Comfort theory and practice: A vision for holistic health care and research*. New York, NY: Springer Publishing Company.

Kolcaba, K., Tilton, C., & Drouin, C. (2006). Comfort theory: A unifying framework to enhance the practice environment. *Journal of Nursing* Administration, *36*(11), 538-543.

Kuebler, K. K., Heidrich, D. E., & Esper, P. (2007). *Palliative & endof-life care: Clinical practice guidelines* (2nd ed.). St. Louis, MO: Elsevier.

Kumekpor, T. K. B. (2002). *Research methods and techniques of social research: Strategic human resource managem*ent. Accra, Ghana: Sonlife Press.

Latour, J. M, Fullbrook, P., & Albarran, J. W. (2009). EfCCNa survey: European intensive care nurses' attitudes and beliefs towards end-of- life care. *Nursing in Critical Care, 14*, 110–121.

Leclerc, B.S., Lessard, S., Bechennec, C., Le Gal, E., Benoit, S., & Bellerose, S. (2014). Attitudes Towards Death, Dying, End-of-Life Palliative Care, and Interdisciplinary Practice in Long Term Care Workers. *JAMDA*, *15*, 207-213.

Leedy, P. D. & Ormrod, J. E. (2010). *Practical research: Planning and design* (9th ed). UpperSaddle River NJ: Pearson

Lima, J. V. F., Guedes, M.V.C., Silva, L. D. F. D., Freitas, M. C. D., & Fialho, A.V.D.M. (2016). Usefulness of the comfort theory in the clinical nursing care of new mothers: Critical analysis. *Revista Gaucha de Enfermagem, 37*(4), 1-4.

Loscalzo, M. J. (2008). Palliative Care: An Historical Perspective. *Haematolgy American Society of Haematology Education Program*, *1*, 465.

Lynch, T., Connor, S., & Clark, D. (2013). Mapping Levels of Palliative Care Development: A Global Update. *Journal of Pain and Symptom Management*, *45*, 1094- 1106.

Macpherson, G. (2002). *Black's Medical Dictionary*. London: A&C Black.

Mastroianni, C., Piredda, M., Taboga, C., Mirabella, F., Marfoli, E., Casale, G., Marinis, M. G. De. (2015). Frommelt Attitudes Toward Care of the Dying Scale Form B : Psychometric Testing of the Italian Version for Students. *OMEGA - Journal of Death and Dying*, *70*(3), 227–250. https://doi.org/10.1177/0030222815568944

Meaza, D., & Worku, Z. (2012). *Knowledge, Attitude and Practice of nurses towards palliative care in Harar National Regional State.* Unpublished manuscript, Department of Nursing, Haramaya University College of Health and Medical Eastern Ethiopia. http//:www.academia.edu

Meier, E. A., Gallegos, J. V., Thomas, L. P. M., Depp, C. A., Irwin, S. A., & Jeste, D. V. (2016). Defining a good death (successful dying): literature review and a call for research and public dialogue. *The American Journal of Geriatric Psychiatry*, *24*(4), 261-271.

Nakazawa Y., Miyashita, M., Morita, T., Umeda, M., Oyagi, Y., & Ogasawara, T. (2009). The palliative care knowledge test: reliability and validity of an instrument to measure palliative care knowledge among health professionals. *Palliative Medicin*e, *23*(8), 54-66. doi: 10.1177/026 9216309106871.

National Council for Palliative Care [NCfPC]. (2002). *Definitions of Supportive and Palliative Care.* London: NCfPC.

National Institute of Health [NIH]. (2012). *End-of-life: Helping with comfort and care.* Maryland, USA: National Institute of Health. Retrieved from https://www.nia.gov/health/publication/end-of-life-comfort-and-care/finding-care-end-life

Nelson, J. E, Meier, D. E, Litke, A., et al. (2004). The symptom burden of chronic critical illness. *Critical Care Medicine*, *32*, 1527–1534. [PubMed: 15241097]

Neuman, W. L. (2003). *Social research methods: Qualitative and quantitative approaches*, (5th ed.). University of Wisconsin at Whitewater: A and B Publishers.

Norlander, L. (2008). *To comfort always: A guide to end of life care*. Indianapolis, IN: Sigma Theta Tau International.

Olthuis, G., Dekkers,W., & Leget, C. (2006). The caring relationship in hospice care: An analysis based on the ethics of the caring conversation. *Nursing Ethics*, *13*, 29–40.

O'Neill, B., & Fallon, M., (1997). ABC of palliative care: Principles of palliative care and pain control. *BMJ, 315*, 801. doi: https://doi.org/10.1136/bmj.315.7111.801

Osuola, E. C. (2001). *Introduction to research methodology*. Onitisha, Nigeria: Africana EEP Publishers Ltd.

Pan, H.-H., Shih, H.-L., Wu, L.-F., Hung, Y.-C., Chu, C.-M., & Wang, K.-Y. (2017). Path modeling of knowledge, attitude and practice toward palliative care consultation service among Taiwanese nursing staff: a crosssectional study. *BMC Pallipative Care*, *16*, 42. http://doi.org/10.1186/s12904-017-0228-6

Payne, R., Madina, E., & Hampton, J. W. (2003). Quality of life concerns in patients with Breast cancer. *American Cancer Society, 97*(1), 311-317.

Peterson, S. J., & Bredow, T. S. (Eds.). (2009). *Middle range theories: application to nursing research*. Philadelphia, PA: Lippincott Williams & Wilkins.

Pope, A. (2013). *Palliative Care Knowledge among Bachelors of Science Nursing Students*. Kennesaw State UniversityDissertations, Theses and Capstone Projects. 596.

Polit, D. F., & Hungler, B.P. (1998). *Essentials of nursing research: methods, appraisal, and utilization* (8th ed.). Philadelphia,

PA: Wolters Kluwer/Lippincott Williams and Wilkins.

Polit, D. F., Beck, C. T., & Hungler, B. P. (2010). *Essentials of nursing research: Methods, appraisal, and utilization.* New York, NY: Lippincott.

Prem, V., Karvannan, H., Kumar, S. P., Karthikbabu, S., Syed, N., Sisodia, V., & Jaykumar, S. (2017). Study of Nurses ' Knowledge about Palliative Care : A Quantitative Cross-sectional Survey. *Indian Journal of Palliative Care, 18*(2), 122–127. https://doi.org/10.4103/0973-1075.100832

Pritchard, M., & Davies, B. (2002). End of life in pediatric oncology: How clinical practice leads to research. *Journal of Pediatric Oncology Nursing, 19*(6), 191-197

Puntillo, K., Nelson, J. E., Weissman, D., Curtis, R., Weiss, S., Frontera, J., & Campbell, M. (2014). Palliative care in the ICU: relief of pain, dyspnea, and thirst: A report from the IPAL-ICU Advisory Board. Intensive Care Medicine, *40*(2), 235-248. http://doi.org/10.1007/s00134-013-3153-z

Razban, F., Iranmanesh, S., & Rafiei, H. (2013). Nurses' attitudes toward palliative care in south-east Iran. *International Journal of Palliative Nursing, 19*(8), 403-410.

Redman, S., White, K., Ryan, E., & Hennrikus, D. (1995). Professional needs of palliative care nurses in New South Wales. *Palliat Med, 9*(1), 36-44.

Rhee, J. J., Zwar, N., Vagholkar, S., Dennis, S., Broadbent, A. M., & Mitchell, G. (2007). Attitudes and barriers to involvement in palliative care by Australian urban general practitioners. *Journal of Palliative Medicine, 11*(7), 980-985.doi: 10.1089/jpm.2007.0251.PMID: 18788958

Román, E.M., Sorribes, E., & Ezquerro, O. (2001). Nurses' attitudes to terminally ill patients. *Journal of Advanced Nursing, 34,* 338-345.

Ronaldson, S., Hayes, L., Carey, M., & Aggar, C. (2008). A study of nurses' knowledge of a palliative approach in residential aged care facilities. *International Journal of Older People Nursing, 3*(4), 258-267.

Ross, M. M., McDonald, B., & McGuinness, J. (1996). The palliative care quiz for nursing (PCQN): The development of an instrument to measure nurses' knowledge of palliative care. *Journal of Advanced Nursing, 23,* 126-137.

Sarfo, L. A., Opare, M., Awuah-Peasah, D., & Asamoah, F. (2016). Knowledge and perception of nurses on palliative care. A case study at Agogo Presbyterian Hospital. *Applied Research Journal*, *1*(4), 39–43.

Saunders, C. (2001). The evolution of palliative care. *Journal of the Royal Society of Medicine,* 94(9), 430

Saunders, M., Lewis, P., & Thornhill, A. (2009). *Research Methods for Business Students*. (5th ed.). London, UK: Pearson Education Limited.

Sanderson, C., & Tieman, J. (2010). Care Search-online palliative care information for GPs. *Aust Family Physician, 39*, 341-3.

Singer, P. A., & Bowman, K. W (2002). Quality end-of-life care: a global perspective. *BMC Palliative Care, 1,* 4.

Sorifa, B., & Mosphea. K. (2015). Knowledge and Practice of Staff Nurses on Palliative Care. IJHRMLP, *1* (2), 41-45.

Skår, R. (2010). Knowledge use in nursing practice: The importance of practical understanding and personal involvement. *Nurse Education Today, 30,* 132-136.

Smeltzer, S. C., Bare, B. G., Hinkle, J. L., & Cheever, K. H. (2010). *Medical-surgical nursing* (12th ed). Philadelphia, PA: Lippincott Williams and Wilkins.

Soyannwo, A., & Amanor-Boadu, S. D. (2001). Management of cancer pain--a survey of current practice in West Africa. *The Nigerian postgraduate medical journal, 8*(4), 175-178.

Storey, S. L., & Ziemba-Davis, M. (2013). Knowledge of palliative care: An evaluation of oncology, intensive care, and heart failure nurses. *Journal of Hospice & Palliative Nursing, 15*(5), 307-315.

Tejad, J. J. & Punzalan, J. R. B. (2012). On the Misuse of Slovins' Formuula. The Philipine Statistician, *61*(1), 129-136.

United Nations programs on AIDS [UNAIDS]. (2010). *UNAIDS Report on the Global AIDS epidemic*. Geneva.

White, K. R., Coyne, P. J, & Patel, U. B. (2001). Are nurses adequately prepared for end-of-life care? *J Nurs Scholarsh, 33*(2), 147-51.

Wilson, O., Avalos, G., & Dowling, M. (2016). Knowledge of palliative care and attitudes towards nursing the dying patient. *British Journal of Nursing, 25*(11), 600-605.

World Health Organization [WHO] (2009). *World Health Organization definition of palliative care*. Geneva, Switzerland: World Health Organization. Retrieved on November 19, 2017 from http://www.who.int/cancer/palliative/definition/en/

World Health Organization [WHO]. (2010). *Palliative Care.* Geneva, Switzerland: World Health Organization. Retrieved from http://www.who.int/cancer/ palliative/ 3.

World Health Organization [WHO] (2018). *Nursing and Midwifery*. Geneva, Switzerland: World Health Organization. Retrieved on June 1, 2018 fromhttp://www.who.int/newsroom/factsheets/detail/nursingandmidwery

APPENDICES

APPENDIX A

UNIVERSITY OF CAPE COAST

COLLEGE OF HEALTH AND ALLIED HEALTH SCIENCES

DEPARTMENT OF NURSING AND MID WIFERY

QUESTIONAIRE FOR NURSES ON PALLIATIVE CARE

TITLE: Assessing Practices of Palliative and End of Life Care among Nurses: A Study at Cape Coast Teaching Hospital

You have been selected to participate in this study to provide information on knowledge, attitude, practice, perceived barriers with regards to palliative and end of life care in nursing practice. The study is important in the sense that it will provide knowledge which can be useful for developing strategies in instituting palliative care in the institution's in-service training program and thus improve the quality of nursing care rendered to the terminally ill or dying patient. Please answer the questions as frankly as you can. Whatever you say will be treated as confidential. Your name will not be associated with the responses you will give. Participation in this research study is voluntary, and you have the right to refuse or discontinue your participation in the study at any time. Thank you in advance for your cooperation.

ID…………………………… Signature………………………

DIRECTIONS: Please tick [√] where appropriate, and for others you may specify by writing.

SECTION A: Demographic Features of respondents

1. Sex: Male [ ] Female [ ]

2. What is your age at last birth day? …………………………

3. Which Ethnic group do you belong to? ....…………………..

4. What is your level of Education? ……….............................

5. Which Ward are your working? …………………………….

6. Working years of experience? ………………………………

7. How often do you care for terminally ill patient (in terms of hours, days weeks, months, and years)?...

8. Do you have any training on palliative care? Yes [ ] No [ ]

9. How long did the training take? …………………………………

SECTION B: **Palliative Care Quiz for Nursing**

Please respond to the following statements about the knowledge you have with regards to palliative care using True, False and Don’t know. Please tick (√) the most appropriate option.

KNOWLEDGE ON PALLIATIVE CARE	True	False	Don’t Know
1. Palliative care is appropriate only in situations where there is evidence of deterioration.			
2. Morphine is the standard used to compare the analgesic effect of other opioids.			
3. The extent of the disease determines the method of pain treatment			
4. Adjuvant therapies are important in managing pain			
5. It is essential for family members to remain at the bedside until death occurs			

6. During the last days of life, the drowsiness associated with electrolyte imbalance may decrease the need for sedation.			
7. Drug addiction is a major problem when morphine is used on a long-term basis for the management of pain.			
8. Individuals who are taking opioids should also follow a bowel regime			
9. The provision of palliative care requires emotional detachment.			
10. During the terminal stages of an illness, drugs that can cause respiratory depression are appropriate for the treatment for severe dyspnea.			
11. Men generally reconcile their grief more quickly than women.			
12. The philosophy of palliative care is compatible with that of aggressive treatment			
13. The use of placebos is appropriate in the treatment of some types of pain			
14. In high doses, codeine causes more nausea and vomiting than morphine.			
15. Suffering and physical pain are synonymous.			
16. Demerol is not an effective analgesic in the control of chronic pain.			
17. The accumulation of losses renders burnout unavoidable for those who seek work in palliative care.			
18. Manifestations of chronic pain are different from those of acute pain.			
19. The loss of a distant or quarrelsome relationship is easier to resolve than the loss of one that is close or intimate.			
20. The pain threshold is lowered by anxiety or fatigue.			

SECTION C: Attitude toward Care of the Dying Scale

Please tick (√) the letter following each statement which corresponds to your own personal feelings about the attitude or situation presented. The meaning of the letters is:

SD=Strongly Disagree; D=Disagree; U=Uncertain; A=Agree; SA=Strongly Agree

NURSES ATTITUDE TOWARDS CARE OF THE DYING	SD	D	U	A	SA
1. Giving care to the dying person is a worthy experience.					
2. Death is not the worst thing that can happen to a person.					
3. I would be uncomfortable talking about impending death with the dying person.					
4. Caring for the patient's family should continue throughout the period of grief and bereavement.					
5. I would not want to care for a dying person					
6. The non-family caregivers should not be the one to talk about death with the dying person.					
7. The length of time required to give care to a dying person would frustrate me					
8. I would be upset when the dying person I was caring for gave up hope of getting better.					
9. It is difficult to form a close relationship with the dying person.					
10. There are times when death is welcomed by the dying person					
11. When a patient asks, "Am I dying?" I think it is best to change the subject to something cheerful.					
12. The family should be involved in the physical care of the dying person.					
13. I would hope the person I'm caring for dies when I am not present					
14. I am afraid to become friends with a dying person.					
15. I would feel like running away when the person actually died					

16. Families need emotional support to accept the behaviour changes of the dying person.					
17. As a patient nears death, the non-family caregiver should withdraw from his or her involvement with the patient.					
18. Families should be concerned about helping their dying member make the best of his or her remaining life.					
19. The dying person should not be allowed to make decisions about his or her physical care.					
20. Families should maintain as normal an environment as possible for their dying member.					
21. It is beneficial for the dying person to verbalize his or her feelings.					
22. Care should extend to the family of the dying person.					
23. Caregivers should permit dying persons to have flexible visiting schedules.					
24. The dying person and his or her family should be the in-charge decision makers.					
25. Addiction to pain relieving medication should not be a concern when dealing with a dying person.					
26. I would be uncomfortable if I entered the room of a terminally ill person and found him or her crying.					
27. Dying persons should be given honest answers about their condition					
28. Educating families about death and dying is not a non-family caregiver's responsibility.					
29. Family members who stay close to a dying person often interfere with the professional's job with the patient.					
30. It is possible for non-family caregivers to help patients prepare for death.					

SECTION D

Please respond to the following statements about how well you practice palliative and end of life care by indicating (√) Yes or No to the options in each domain.

	PILLIATIVE CARE PRACTICE	YES	NO
1	**Initiate palliative care discussion**		
A	During diagnosis		
B	When the disease progress		
C	At the end of life		
2	**Do you inform terminally ill patient about their diagnosis?**		
3	**Factors considered when dealing with terminally ill patient**		
A	Spiritual		
B	Medical situation		
C	Cultural		
D	Psychological		
4	**How do you address patient's spiritual issues?**		
A	Connect with spiritual counsellor		
B	Listen with empathy		
C	Impose your own view		
D	Understand patient reaction		
5	**What should Cultural assessment during patient care include?**		
A	Truth telling and decision making		
B	Preference regarding disclosure of information		
C	Dietary preference		
D	Language, family communication		
E	Perspective on death, suffering & grieving		
6	**How do you address patient's psychological issue**		
A	Emotional support		
B	Counselling the patient		
C	Hiding the truth		
7	**Whom do you involve in decision making?**		
A	Patient		
B	Family		
C	My own		
D	Other health professional		

8	**How do you perceive terminally ill patient concern or question?**		
A	Patient right		
B	Treat.		
C	Doubting your professionalism		
D	Attention seeking behaviour		
9	**Communication to the family of terminally ill patient depends on:**		
A	Family's ability to assimilate		
B	Their involvement in decision making		
C	Your willingness to disclose information		
10	**Commonly use medication in your practice for severe pain?**		
A	Paracetamol/Ibuprofin		
B	Codeine		
C	Morphine		
11	**How do you assess patient pain?**		
	Grade with face		
	Intensity		
	Location		
	Quality		

SECTION E

Questions On Perceived Barriers to Palliative Care Practice. Please tick [√] 'Yes' or 'No' where appropriate, and for others you may specify by writing.

1. What do you think is barrier to the palliative care practices among nurses?

Barriers to PC	**YES**	**NO**
1. Poor funding		
2. Restrictions on opioid availability		
3. Negative attitudes of healthcare professionals		
4. Low levels of public awareness		

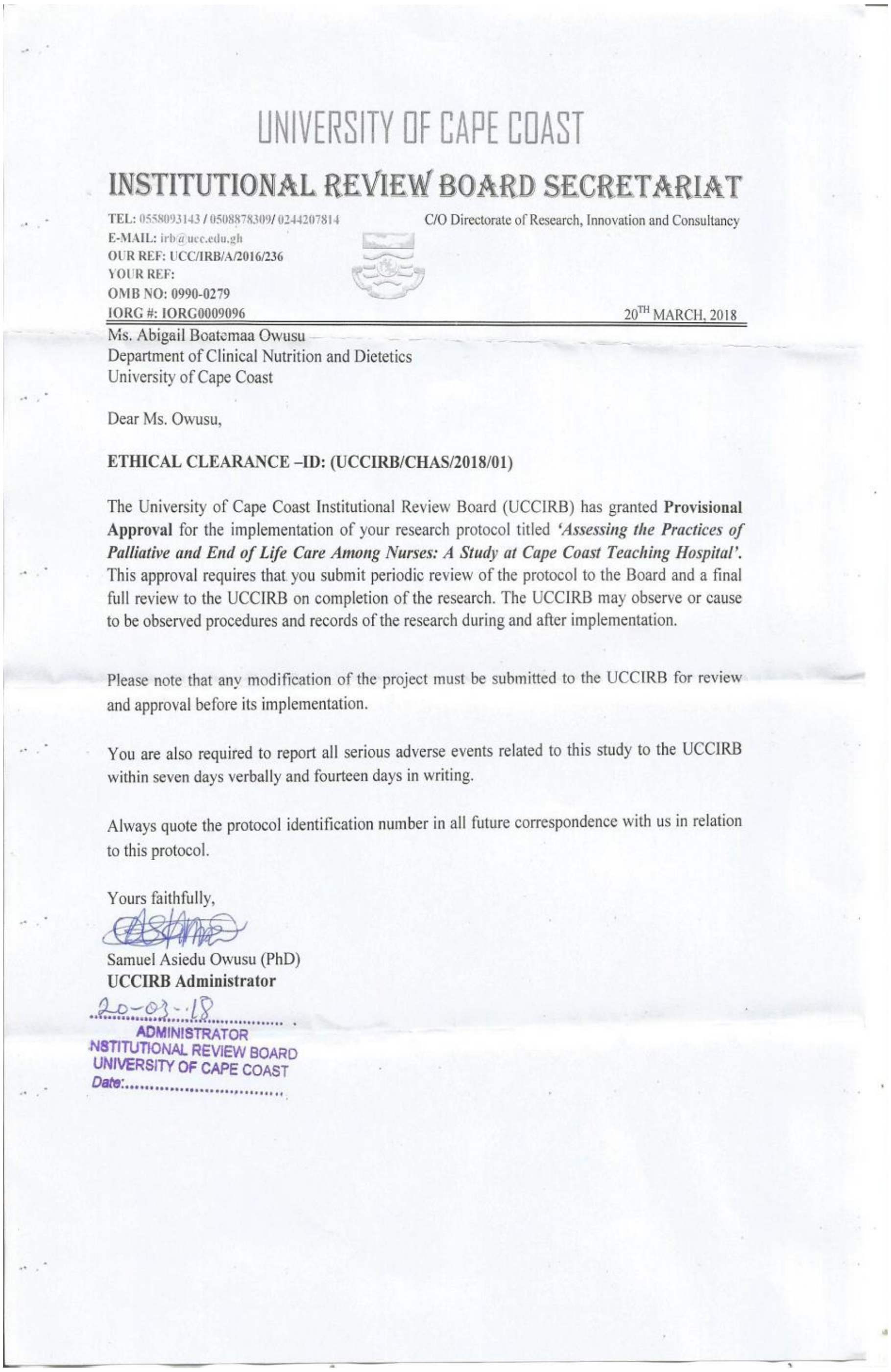
5. Inadequate education		
6. Absence of curriculum content related to palliative care		
7. Stress in caring for terminally ill patient		

2. What are some of the strategies that could be adopted to reduce the perceived barriers of palliative care?
…………………………………………………………………………………
…………………………………………………………………………………
…………………………………………………………………………………
…………………………………………………………………………………

THANK YOU

APPENDIX B

ETHICAL CLEARANCE FROM UCC IRB



UNIVERSITY OF CAPE COAST

INSTITUTIONAL REVIEW BOARD SECRETARIAT

TEL: 0558093143 / 0508878309/ 0244207814
E-MAIL: irb@ucc.edu.gh
C/O Directorate of Research, Innovation and Consultancy

OUR REF: UCC/IRB/A/2016/236
YOUR REF:
OMB NO: 0990-0279
IORG #: IORG0009096

20TH MARCH, 2018

Ms. Abigail Boatemaa Owusu
Department of Clinical Nutrition and Dietetics
University of Cape Coast

Dear Ms. Owusu,

ETHICAL CLEARANCE –ID: (UCCIRB/CHAS/2018/01)

The University of Cape Coast Institutional Review Board (UCCIRB) has granted **Provisional Approval** for the implementation of your research protocol titled ***'Assessing the Practices of Palliative and End of Life Care Among Nurses: A Study at Cape Coast Teaching Hospital'.*** This approval requires that you submit periodic review of the protocol to the Board and a final full review to the UCCIRB on completion of the research. The UCCIRB may observe or cause to be observed procedures and records of the research during and after implementation.

Please note that any modification of the project must be submitted to the UCCIRB for review and approval before its implementation.

You are also required to report all serious adverse events related to this study to the UCCIRB within seven days verbally and fourteen days in writing.

Always quote the protocol identification number in all future correspondence with us in relation to this protocol.

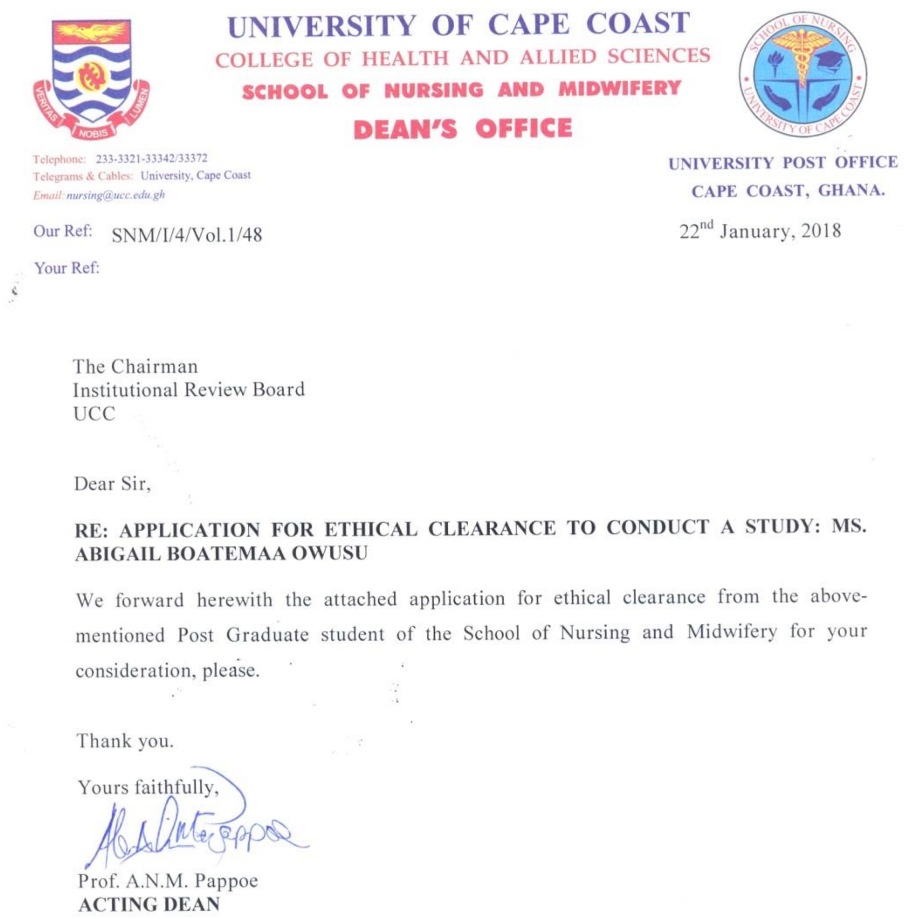
Yours faithfully,

Samuel Asiedu Owusu (PhD)
UCCIRB Administrator

20-03-18
ADMINISTRATOR
INSTITUTIONAL REVIEW BOARD
UNIVERSITY OF CAPE COAST
Date:

APPENDIX C

APPLICATION FOR ETHICAL CLEARANCE



UNIVERSITY OF CAPE COAST
COLLEGE OF HEALTH AND ALLIED SCIENCES
SCHOOL OF NURSING AND MIDWIFERY
DEAN'S OFFICE

Telephone: 233-3321-33342/33372
Telegrams & Cables: University, Cape Coast
Email: nursing@ucc.edu.gh

UNIVERSITY POST OFFICE
CAPE COAST, GHANA.

Our Ref: SNM/I/4/Vol.1/48

22nd January, 2018

Your Ref:

The Chairman
Institutional Review Board
UCC

Dear Sir,

RE: APPLICATION FOR ETHICAL CLEARANCE TO CONDUCT A STUDY: MS. ABIGAIL BOATEMAA OWUSU

We forward herewith the attached application for ethical clearance from the above-mentioned Post Graduate student of the School of Nursing and Midwifery for your consideration, please.

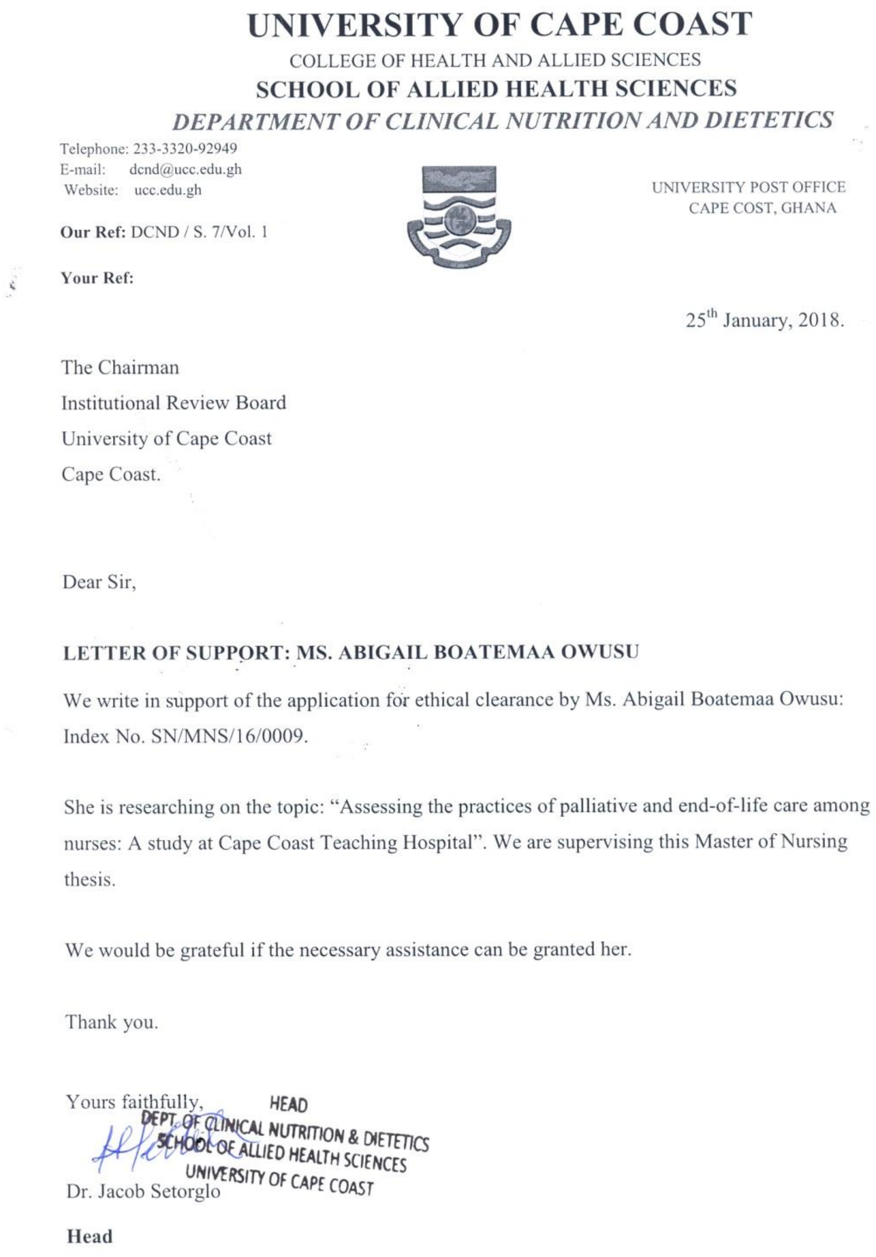
Thank you.

Yours faithfully,

Prof. A.N.M. Pappoe
ACTING DEAN

APPENDIX D

INTRODUCTORY LETTER



UNIVERSITY OF CAPE COAST
COLLEGE OF HEALTH AND ALLIED SCIENCES
SCHOOL OF ALLIED HEALTH SCIENCES
DEPARTMENT OF CLINICAL NUTRITION AND DIETETICS

Telephone: 233-3320-92949
E-mail: dcnd@ucc.edu.gh
Website: ucc.edu.gh

UNIVERSITY POST OFFICE
CAPE COST, GHANA

Our Ref: DCND / S. 7/Vol. 1

Your Ref:

25th January, 2018.

The Chairman
Institutional Review Board
University of Cape Coast
Cape Coast.

Dear Sir,

LETTER OF SUPPORT: MS. ABIGAIL BOATEMAA OWUSU

We write in support of the application for ethical clearance by Ms. Abigail Boatemaa Owusu: Index No. SN/MNS/16/0009.

She is researching on the topic: "Assessing the practices of palliative and end-of-life care among nurses: A study at Cape Coast Teaching Hospital". We are supervising this Master of Nursing thesis.

We would be grateful if the necessary assistance can be granted her.

Thank you.

Yours faithfully,

HEAD
DEPT. OF CLINICAL NUTRITION & DIETETICS
SCHOOL OF ALLIED HEALTH SCIENCES
UNIVERSITY OF CAPE COAST

Dr. Jacob Setorglo
Head

APPENDIX E

CCTH INSTITUTIONAL APPROVAL

In case of reply the reference number
and the date of this
Letter should be quoted

Our Ref.: CCTH/RDS/2018/26

Your Ref. SNM/R/2/Lol.2/67

P. O. Box CT.1363
Cape Coast
Tel: 03321-34010-14
Fax: 03321-34016
Website: www.ccthghana.org
email: info@ccthghana.com

29th May 2018

Ms Abigail Boatemaa Owusu
Masters Student
University of Cape Coast
College of Health and Allied Sciences
School of Nursing and Midwifery
Cape Coast

Dear Ms Owusu

R&D SECRETARIAT'S INSTITUTIONAL APPROVAL

The Cape Coast Teaching Hospital Research and Development Secretariat (CCTHRDS) have assessed your research topic, **"Assessing the Practices of Palliative and End of Life Care Among Nurses: A Study at Cape Coast Teaching Hospital"** which was submitted for institutional approval. The secretariat writes to inform you of the decision to grant you CCTH institutional approval to undertake the study at CCTH.

You are however required to **submit an electronic copy of your findings from the research in the form of an abstract to the CCTHR&D Secretariat email address:** ccthresearch@gmail.com

Always quote our ref. identification number above in all future correspondence with us in relation to this research study.

Yours sincerely,

Ms. Princess G. Ofori
Head, Research, Monitoring & Evaluation

CC. DDNS'/Heads of Sub-BMC (Surgical, Internal Medicine, Child Health, Maternal Health)