

CARING FOR PATIENTS IN PALLIATIVE HOME CARE: A QUALITATIVE STUDY ABOUT NURSES' EXPERIENCES

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CARING FOR PATIENTS IN PALLIATIVE HOME CARE: A QUALITATIVE STUDY ABOUT NURSES' EXPERIENCES

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Key words: palliative care, home care, ethics, nurses

Abstract

Background. In palliative care, nurses find it difficult to deal with ethical dilemmas and have insufficient skills to solve them. Unresolved ethical dilemmas can lead to a state of moral distress, which can lead nurses to distance themselves from their patients. In palliative home care, nurses find it important to be close to their patients. Moral distress and, in reaction, nurses' act of distancing, could be threats to the quality of palliative home care.

Aim. The aim of this study is to gain an understanding in how nurses experience caring for patients and experience ethical dilemmas in Dutch palliative home care settings. With this understanding, educational programs can be developed to train and guide nurses to address ethical dilemmas and to prevent moral distress when providing palliative home care.

Research question. How do nurses experience caring for patients in a palliative home care setting?

Methods. A Grounded Theory approach was used. The population consists of palliative home care nurses. Data were collected through nine individual in-depth interviews. The steps in Grounded Theory were followed during data analysis.

Results. The emerging themes were *building relationships*, *problems in palliative home care* and *motivation to do as good as possible*. Nurses experienced problems, caused by opposing ideas of GP's and family members, lack of communication between patients and partners, structure of palliative home care and patients' suffering. If problems were looked upon as moral problems or ethical dilemmas, nurses distanced themselves from these problems, by guarding their emotions and trying to solve them with patients' values, due to their perception that patients' autonomy was most important.

Conclusion. The results highlight the need to develop educational training for nurses to address ethical dilemmas when providing palliative home care. This study may provide a basis to develop strategies for nurses in palliative home care to cope with ethical dilemmas and prevent themselves from moral distress.

VERPLEGEN VAN PATIENTEN IN DE PALLIATIEVE THUISZORG: EEN KWALITATIEVE STUDIE OVER DE ERVARINGEN VAN VERPLEEGKUNDIGEN

Nout Willems & Jean-Jacques Georges

Sleutelwoorden: palliatieve zorg, thuiszorg, ethiek, verpleegkundigen

Samenvatting

Achtergrond. Verpleegkundigen in de palliatieve zorg vinden het moeilijk om met ethische dilemma's om te gaan en hebben onvoldoende vaardigheden om ze op te lossen. Onopgeloste ethische dilemma's kunnen leiden tot morele nood, met als gevolg dat verpleegkundigen zich distantiëren van hun patiënten. Dit zou een bedreiging kunnen zijn voor de kwaliteit van de palliatieve thuiszorg.

Doel. Het doel is inzicht te verkrijgen in hoe verpleegkundigen de zorg voor patiënten en ethische dilemma's ervaren in de Nederlandse palliatieve thuiszorg. Met dit inzicht kan scholing worden ontwikkeld om verpleegkundigen in de palliatieve thuiszorg te trainen en te begeleiden om met ethische dilemma's om te gaan en morele nood te voorkomen.

Onderzoeksvraag. Hoe ervaren verpleegkundigen de zorg voor patiënten in de palliatieve thuiszorg?

Methode. Dit kwalitatieve onderzoek heeft gebruik gemaakt van de Grounded Theory benadering. De populatie bestaat uit verpleegkundigen in de palliatieve thuiszorg. De gegevens werden verzameld door middel van negen individuele diepte-interviews. De stappen in Grounded Theory werden gevolgd tijdens de data-analyse.

Resultaten. De thema's waren *opbouwen van relaties, problemen in de palliatieve thuiszorg* en *motivatie om alles zo goed mogelijk te doen*. Verpleegkundigen beschreven problemen, veroorzaakt door tegengestelde ideeën van huisartsen en familieleden, gebrek aan communicatie tussen patiënten en partners, de structuur van de palliatieve thuiszorg en door het lijden van patiënten. Indien verpleegkundigen deze problemen zagen als morele problemen of ethische dilemma's, distantieerden ze zich van deze problemen, door hun emoties af te schermen ze te proberen op te lossen met de waarden en normen van de patiënt, omdat ze de autonomie van de patiënt het belangrijkste vonden.

Conclusie. De resultaten benadrukken de noodzaak om scholing te ontwikkelen voor verpleegkundigen, gericht op het omgaan met ethische dilemma's in de palliatieve thuiszorg. Dit onderzoek zou een basis kunnen zijn voor verpleegkundigen in de palliatieve thuiszorg, om strategieën te ontwikkelen voor het omgaan met ethische dilemma's en het voorkomen van morele nood.

Introduction

In the Netherlands, terminally ill patients prefer to spend the end-of-life at home, where care and support are aimed at maintaining quality of life and comfort¹. 63% of all people over 55 years old stays at home three months before death. Only 31% actually dies at home². In these situations, home care nurses often carry out palliative care. Palliative care is most commonly defined by the World Health Organization as: *“An approach that improves the quality of life of patients and their families facing the problem associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychological and spiritual”*³.

Western European and Canadian study results show that in palliative home care, nurses feel that it is important to be close to their patients and often feel the moral responsibility to alleviate patients' suffering and to solve their problems. The uncertainty about choices nurses then have to make, can lead to the experience ethical dilemmas⁴⁻⁷. One review identified that, next to the confrontation with suffering patients, the adequacy of treatment, the communication with patients and family and end-of-life issues, also create situations in palliative care, in which nurses experience ethical dilemmas⁸. Dutch study results, based on structured questionnaires, show that nurses face ethical dilemmas because of their own ideas of what good care should be in a changing Dutch healthcare system, where lack of finances and health personnel are growing issues. Therefore nurses often feel being divided between their caring philosophy and external rules and regulations⁹.

The experience of an ethical dilemma is the experience of an uncertain situation, in which people feel the moral responsibility to choose between two or more good or bad solutions, in order to resolve moral problems¹⁰. The cornerstones of ethical dilemmas are the obligation to choose between two or more options, the absence of the best justifiable option, and the known fact that the consequences of all options would harm yourself and others⁹.

Nurses find it difficult to deal with ethical dilemmas and often do not recognize the moral dimensions of problems in palliative care. They also do not possess sufficient skills to solve ethical dilemmas and should develop themselves better in that regard⁸⁻¹⁰. Unresolved ethical dilemmas can lead nurses to a state of moral distress, which is the internal conflict regarding to the uncertainty of the morally right solutions¹¹. In reaction to ethical dilemmas and moral distress, nurses in palliative care tend to distance themselves from their patients by setting personal boundaries and trying to maintain their professionalism, in order to become not too emotionally involved¹²⁻¹³.

Problem statement

There is evidence that nurses in palliative care find it difficult to deal with ethical dilemmas and have insufficient skills to solve them. Unresolved ethical dilemmas can lead to moral distress and distancing oneself from patients. Given the importance of being close to patients in palliative home care, nurses' moral distress and, in reaction, their act of distancing, could be threats to the quality of palliative home care. There is no qualitative evidence about how nurses in Dutch palliative home care, experience caring for patients and deal with ethical dilemmas.

Aim

The aim of this study is to gain an understanding in how nurses experience caring for patients and experience ethical dilemmas in Dutch palliative home care settings. With this understanding, educational programs can be developed to train and guide nurses to address ethical dilemmas and prevent moral distress when providing palliative home care.

Research question

- How do nurses experience caring for patients in a palliative home care setting?

Sub questions

- What are nurses' experiences with ethical dilemmas when caring for patients in a palliative home care setting?
- Which factors influence nurses' experiences of ethical dilemmas when caring for patients in a palliative home care setting?

Methods

Design

In this qualitative study, a Grounded Theory approach was used, according to Strauss & Corbin¹⁴. This approach allowed a broad exploration of nurses' experiences when caring for patients and let relevant ideas and theories to develop.

Population and sample

The population consists of nurses who carry out palliative care to patients in a Dutch home care setting. Inclusion criteria were: being a nurse with or without a bachelor's degree, working for at least one year in home care and have had at least one professional contact with a patient in a palliative home care setting. Participants had to express themselves in Dutch language.

Purposeful convenience and snowball sampling were used to select participants. Participants were approached by the researchers' contact persons within a Palliative Network in the Netherlands. The study was carried out from January until June 2011. The contact persons of the Palliative Network were given a presentation about the study and informed the researcher about possible participants. The researcher selected participants based on the inclusion criteria. After selection, participants were informed about the study by the researcher and were enrolled, if informed consent was given.

Data collection

Data was collected through individual in-depth interviews at participants' workplaces, that each took up to one hour. Through interviewing, the researcher was able to explore experiences and perceptions of nurses thoroughly. During the interviews, an interview guide, as proposed by Holloway & Wheeler¹⁵ and Polit & Beck¹⁶, was used (Appendix 1). The interview guide contained a central question to start the in-depth phase of the interview: "*Tell me about your experiences with caring for patients in palliative home care*". Two other central questions were focussed on *problems* and *ethical dilemmas* in palliative home care. The interview guide contained probe questions to understand respondents' experiences. During data collection, the topics *relationships* and *motivation to work* were added to the interview guide. Interviews were tape recorded, transcribed verbatim and encoded. The qualitative software program WinMax 98 Pro¹⁷ was used for data analysis.

Data analysis

For data analysis, the steps in Grounded Theory, as described by Strauss & Corbin¹⁴, were followed. The first step was the reading of the text thoroughly. Through open coding of explicit or remarkable statements, interviews were brought back to several codes. The second step was finding a link between the codes. In this process of axial coding, relationships between the codes were searched, in order to form categories. In the third step of selective coding, categories and their relationship to each other were described to clarify nurses' experiences. To firmly establish relationships between the categories, data collection and analysis succeeded each and coding and categorising involved constant comparison.

Trustworthiness

In order to enhance trustworthiness, the researcher followed training in interviewing and analyzing qualitative data. In search for negative cases, the researcher asked participants to describe situations where experiences were different as that they just described. The researcher asked for clarification, when necessary. The peer graduate students, course mentor and supervisor, critically reviewed the steps made by the researcher.

The supervisor also reflected on the coding, by independently coding the interviews and comparing interpretations. Due to his experience as a home care nurse and membership of the Palliative Network, the researcher was able to call attention to the sensitizing concepts. During the whole study, the researcher took memos of his own thoughts, interpretations and questions, which were used for bracketing and reflection. For reflexivity reasons, the researcher enrolled participants with whom there was no prior relationship.

Ethical considerations

This study was not bound up by medical ethical laws¹⁸ in the Netherlands. Participants' informed consent was aimed at voluntary and anonymous participation.

Results

Nineteen home care nurses were approached to participate in the study. Ten nurses withdrew, due to their heavy workload or fear of intimate questions. A total of nine home care nurses participated. Mean age was 41 years old (-18/+13). Mean work experience in palliative home care was 11 years (-9.5/+12). Education details and work experience are listed in appendix 2.

The findings are presented based on the emerging themes of *building relationships*, *problems in palliative home care* and *motivation to do as good as possible*.

Building relationships

Building relationships was important to all respondents. In the first contact with patients, they determined if the relationship could be build. This was called *the connection* with patients. Three respondents described the uniqueness of being allowed to engage in an intimate relationship with patients.

R5: "They are often emaciated, incontinent, vomiting...all facets they prefer to keep to their selves, and just then they have to admit so many people. That makes me even more aware of the uniqueness of being connected to someone leaving earth."

Some respondents felt responsible for establishing a connection. Four respondents stated that building a relationship depended on the thrust they could inspire. Respondents tried to inspire that thrust by gaining insight in patients' experiences, being honest, being open or trying to adapt to the patients level.

R4: "I'm a professional, I have to put myself in their place to make that connection."

R3: "We can't get through, his feelings..that's really a difficult situation. If I am sure there is no need to connect, it's all right. But sometimes... I see it in their eyes."

Gaining insight in patients' experiences was easier for some respondents if patients were the same age. The relationship with young patients was described as special, but difficult. Even more when respondents could imagine the life patients could have had.

R1: "If I put myself in their place, if I would be so young ...That's more difficult then with someone who is very old and have had a good life."

Six respondents described that relationships are build in situations where there is frequent and prolonged contact with patients. This gives them time to get themselves involved and committed.

R6: "If you care for someone for 5 hours a week, then you build a relationship."

Five respondents described that, although the relationship with their patients was strong, they did not feel deep personal emotions. These respondents guarded their emotions and set aside their personal values. Moral problems faced by patients were seen as patients' problems that needed to be solved with patients' values. This prevented the respondents from coming into conflict with their own values. Also two respondents described that they distanced themselves from moral problems, as part of their professionalism.

R7: "I pity those patients, but without my own emotions. Those are guarded. [...] There are hardly emotions. That is my professionalism".

R4: "I'll be less likely to come into conflict with my values...because it's their problem."

Some respondents described this problem solving strategy as patient centred care, wherein patient's autonomy was most important. For that reason, they often needed to be flexible by not only setting aside their personal values, but also their professional values and interpret them in each individual situation.

R3:" The protocol is exact, in how you should conduct the home visits, what should be discussed. This should be right, but I do not follow them."

R4: "I think I can best describe it as that I'm the one who lets the patient take control. They take control with their own background and their own values. That means that I have to set aside my values as a nurse."

Two respondents stated that sharing their private lives with patients is a natural thing to do in palliative home care. In contrast, two respondents described that they only share superficial information about their own private lives. Personal boundaries were different within the respondents. Some set their boundary when they think their personal family life is affected by the situation. Others had the perception that giving flowers crosses personal boundaries. But all respondents mention that it is important to separate private life with professional contacts.

R7: "If it becomes too friendly, you really have to watch out. It's fine if you have one patient, where you overstep your professional boundaries. But if you have ten, you don't have a private life anymore."

Problems in palliative home care

Opposing idea's of GP's

Respondents described that their experiences with GP's were diverse. With some GP's collaboration was easier than with others. Six respondents described their experiences regarding problems with GP's about the palliative medical policy. One younger respondent found it to be difficult, when GP's did not cooperate and when medical policy was not clear.

R1: "If someone is dying at home and the GP does not come over, that's really sad. And then, in the final phase, policy to continue nutritional drinks or tube feeding, that's very difficult for me."

Other respondents, who worked in a Reformed Christian area, described that they found it to be difficult to discuss end-of-life issues with Christian Reformed GP's. Especially when they had the perception that the GP involved, was not willing to act on the patients' burden. One respondent, who had worked in urban and Reformed Christian areas, expressed the advantage of Reformed Christian GP's, to be creative in relieving patients' suffering in other ways than prescribing medication.

R6: "And that doctor was very careful to start with Dormicum, and I thought... what are you doing! Soon he will wake up..is that what you want!."

R3: "And yet, you see the creativity that those doctors use. Most people still have a beautiful death without all that drugs."

One respondent experienced a good collaboration with GP's. His approach to negotiate with GP's was mainly based on rationalizing the problems he encountered and stressing the importance of medical protocols. Others found it more difficult to negotiate with GP's regarding end-of-life decisions.

They strove to act as patients' advocates; however, they realized that some decisions concerning the end-of-life could only be taken by the patient and the GP.

R2: "If people have questions, we explain how things work. But we make it very clear that the decision is to the GP... I think it belongs there."

Opposing idea's of family members

All respondents indicated that family is an important part of palliative care. However, they observed that family members could cause problems due to their opposing ideas of medical policy. In reaction, they tried to clarify patient's point of view to family members.

R8: "When family members don't agree with the patients' wishes for sedation or euthanasia... then I feel uncomfortable, that's very difficult."

R5: "As long as the patient is conscious of his actions, he has the last say. And then I let the family to understand this"

Lack of communication between patients and partners

Six respondents faced problems regarding family, when the patient and his partner did not communicate with each other or fought over medical policy. Some respondents were inclined to the partner's point of view when judging who was right. Not being able to solve these conflicts caused feelings of powerlessness. Some respondents often doubted whether they should intervene or not.

R1: "She (patient) always snapped at him, and he tried so hard to please her. I said to her: 'look what he does for you!' But that was difficult. I didn't want to judge, but I didn't think she was right."

R2: "I question my interference and closeness in these situations. Shouldn't I distance myself? I'm a professional; I also have to maintain a certain distance!"

Structure of palliative home care

Some respondents described that solving patients' problems can be difficult, because of practical obstacles in palliative home care, such as communication with and availability of colleagues and GP's.

R2: "The contact with GP's and other colleagues is difficult, due to our solitude work environment. I do feel responsible, so I put a lot of effort in communication with them. But sometimes I have to give up."

Five respondents described, that over the last decade, due to function level differentiation, they mainly come in contact with patients in a terminal phase, where care and support are aimed at symptom control. According to some respondents, this is why taking responsibility for every aspect of palliative care is sometimes difficult.

R3: "Over the last years, we are called upon very late, only in the terminal phase. We used to be called upon much earlier."

Also the time constraints, insufficient staff and resources were described as problems by several respondents, which could lead to feelings of frustration.

R9: "This bureaucracy...we are talking about terminal patients who want to go home. When there is no special bed, no bed-pan, no IV pole...In my head I get furious, but I have to deal with the situation as it is."

Suffering patients

Situations, in which patients were suffering or struggling with the end-of-life, were described as difficult to deal with. Some respondents described they felt responsible for the patients' suffering. When they or the GP were not able to control patient's suffering or when the GP didn't pay enough attention to patient's wishes, they felt frustrated and powerless. A way of handling those situations was focusing on practical comfort in the home.

R4: "There are people who go down fighting. And that affects you personally. I do more for those people; I see them several times a day."

R8: "I felt powerless, I could not help him. I got really angry. Because the GP didn't do justice to his patient."

Motivation to do things as good as possible

Some respondents explained that caring for patients in palliative home care above all meant a careful and accurate approach to offer comfort, being conscious of only having one chance to do things as good as possible. Offering comfort was seen as technical and practical support, like symptom control or organizing the home.

R7: "It is the final stage that people experience with their family, and you want that to be positive. Because you can't redo it." [...] "You organize pain, shortness of breath..symptoms may stay, but you organize them to make them bearable."

Appreciation and affirmation by family members, that everything was done right, was seen as very important by many respondents and contributed to a nice feeling when closing a care situation. Respondents actively evaluated the quality of care and checked their actions with family members in a last home call.

R8: "I ask explicitly how they evaluate my performance...I always like to know."

R5: "If family members evaluate care as good, it is easier to get closure."

It seemed important to them to evaluate their role at the end of the day. Their self-evaluation and evaluation with colleagues was focused on checking actions and ventilating emotions. Four respondents described that checking actions, mostly done in car rides home or to the next patient, is a way to empty oneself.

R1: "I think that it is important to evaluate with your colleagues. Then you look back on what you've done well, and what can you do better."

R6: "I am glad that I sometimes have to drive far. It gives me time to check if I have done everything the right way."

Discussion

The emerging themes of *building relationships*, *perception of problems* and *motivation to do as good as possible* describe nurses' experiences with caring for patients and ethical dilemmas in palliative home care.

Building relationships with patients was seen as very important. Inspiring thrust, gaining insight in patients' experiences, prolonged contact and being open and honest, favorably influences that relationship. Most participating nurses seemed to guard their emotions and avoided getting into conflict with themselves, as a part of their profession. Moral problems and ethical dilemmas were solved with patients' values, due to nurses' perceptions that patients' autonomy was very important.

The results show that nurses mostly face moral problems when GP's or family members have opposing ideas of palliative medical policy. Some nurses have difficulties grounding their actions to react in these situations, as well in situations where there is poor communication between patients and partners and in which patients are suffering. The focus on the terminal phase of palliative care and the lack of time, staff and other resources were also problems that nurses encountered, which caused feelings of frustration and powerlessness.

The motivation to do as good as possible, was related to the fact that nurses seem to have the perception only to have one chance to do things right. In evaluating care, nurses find it important to check their actions with family members, colleagues and with themselves.

Few qualitative studies tried to describe how nurses in palliative home care experience caring for patients. In a Swedish phenomenological study¹⁹ about the meaning of caring in palliative care, results show that home care nurses find the unpredictability in palliative homecare challenging, feel that they need to be in control over the situation, feel frustrated due to lack of time and find relationships with patients and families very important. This was also underlined by the results of the present study, except the need to be in control over the situation. Patient's autonomy was seen as more important than being in control.

A Canadian casestudy²⁰ shows that nurses, when entering patients' homes, are determined to personally engage with whatever is going on. In this current study, home care nurses made clear it was important to engage with their patients, however, because of their conceptions about respecting patient's autonomy they seemed to distance themselves when problems occurred, trying above all not to take position.

One qualitative study²¹, which was carried out in palliative home care in the UK reported on nurses' avoidance and blocking strategies when patients showed signs of distress. A Swedish study²² also describes that nurses in hospital settings, *strive for emotional survival*, as the pattern behaviour through which nurses in palliative care deal with the risk of being emotionally overloaded by their work. In the present study, nurses also guarded themselves to become too emotionally involved and overloaded by their work, when faced with moral problems. Except for *emotional postponing*, nurses' *emotional shielding by professional shielding*, *confirmation seeking* and *self-reflection*, as mentioned in the Swedish study, were also found in this present study.

Strengths and weaknesses

Withdraw and time restraints caused that no more than nine respondents participated in the study. Therefore it is uncertain if saturation was achieved. Although the findings may be transferable to other populations, they are not generalizable. Because respondents mainly reported on patients in the final three months of their disease, the results mostly describe their experience when caring for patients during the terminal phase of their illness.

This study was in-depth, carried out within six different organisations and none of the nurses who participated worked directly with each other. The variation of experiences was therefore full. Withdraw was only partially visible to the researcher. The nurses who participated in this study may have had a greater interest in palliative care and ethical dilemmas, especially knowing some reasons for withdraw, like the fear of too intimate questions. However, given that these nurses were more interested in the topics, they still had difficulty dealing with ethical dilemmas and moral problems.

Conclusion

The findings in this study give insight in nurses' experiences when caring for patients in palliative home care and with ethical dilemmas. When problems are looked upon as moral problems or ethical dilemmas, it seems that palliative home care nurses refer to the importance of patients' autonomy, which causes them to distance themselves. This distancing behaviour could be enforced by their tendency to guard their emotions to prevent they come into conflict with their selves.

This highlights the need to develop educational training for nurses to address ethical dilemmas when providing palliative home care. This study may provide a basis to develop strategies for nurses in palliative home care to cope with ethical dilemmas and prevent themselves from moral distress.

Recommendations

Further qualitative research is necessary to examine influencing factors of ethical dilemmas and moral distress in palliative home care, including experiences of nurses who work with patients in early stages of the palliative phase. Policy makers should have attention to multidisciplinary palliative home care, where moral deliberation between nurses and GP's is reinforced.

Conflict of interest statement

The authors declare that there is no conflict of interest.

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Appendix 1 Interview guide

Phase	Questions/Topics
Settle-in phase	<ul style="list-style-type: none"> • Ice-braking <ul style="list-style-type: none"> ○ introduction ○ information research ○ getting acquainted • Demographics <ul style="list-style-type: none"> ○ function... ○ initial education... ○ palliative care education... ○ age... ○ working in care since.. ○ working in homecare since... ○ working in palliative care since... ○ last palliative patient...
In-depth dialogue phase	<ul style="list-style-type: none"> • General questions/topics <ul style="list-style-type: none"> ○ Tell me about your experiences with caring for patients in palliative home care. ○ Did you ever experience problems in palliative home care? ○ Did you ever experience ethical dilemmas in palliative home care? • Probe questions <ul style="list-style-type: none"> ○ What were the circumstances... ○ What did you feel... ○ How did you react... ○ How did you handle... ○ What was important... ○ How do you reflect on that...
Closing phase	<ul style="list-style-type: none"> • Closing questions <ul style="list-style-type: none"> ○ Is there anything else you like to tell me? ○ Are there any other questions you think of I should have asked you? • Closing the interview <ul style="list-style-type: none"> ○ How did you experience this interview? ○ Would you mind being contacted again? • Information about study progress <ul style="list-style-type: none"> ○ Time planning study results

Appendix 2 Demographics table

Respondent	Age	Education	Work experience palliative home care (years)	Work details
R1	23	Nursing, without bachelors degree, training in palliative care	3.5	All-round home care nurse and palliative care specialist
R2	48	Nursing, without bachelors degree, training in oncology and palliative care	22	All-round home care nurse, palliative care specialist and care coordinator
R3	46	Nursing with bachelors degree, training in oncology and palliative care	16	All-round home care nurse, palliative care specialist and care coordinator
R4	44	Nursing with bachelors degree, training in oncology, palliative care and children's' ICU	6	Technical home care nurse, specialist in technical end-of-life activities
R5	49	Nursing with bachelors degree, training in oncology and palliative care	11	All-round home care nurse, palliative care specialist and care coordinator
R6	26	Nursing with bachelors degree, training in oncology and palliative care	4	All-round home care nurse, palliative care specialist, care coordinator and teacher in Nursing
R7	54	Nursing with bachelors degree, training in oncology and palliative care	23	All-round home care nurse, palliative care specialist and care coordinator
R8	48	Nursing, without bachelors degree, training in palliative care	13	All-round home care nurse in night shifts
R9	31	Nursing with bachelors degree, training in palliative care	1.5	All-round home care nurse
Mean	41		11	