Developing a culture-based palliative nursing care model in hospitals: a phenomenological study

Israfil Israfil, Ni Luh Putu Inca Buntari Agustini, I Ketut Swarjana

Department of Nursing, Faculty of Health, Institute of Technology and Health Bali, Indonesia

Abstract

Palliative care serves as a framework for nurses to provide quality care. A cultural approach is essential for helping palliative care patients access maximum health services. This study aimed to determine the important aspects of developing a culture-based palliative nursing care model. Utilizing a qualitative, phenomenological design, this research involved 11 participants, including nurses, palliative care patients, and their families. Data collection was conducted through focus group discussions, and analysis was performed using the thematic method with the Colaizzi approach. Five key themes emerged to develop a culture-based palliative nursing care model: i) patient condition (knowledge, psychological challenges, education, and age); ii) family support (psychological state, knowledge, communication, assistance, and economic status); iii) role of nurses (advocacy, education, caring attitude, help with Activity of Daily Living [ADL], and give realistic expectations); iv) health service policies (no code blue, supportive therapy, entertainment, availability of resources, teamwork, chemotherapy, and health insurance); and v) cultural influence (spiritual needs, fear of death, desire not to die at home, Internet use, and alternative medicine). All these components are crucial for the enhancement of palliative nursing care.

Correspondence: Ni Luh Putu Inca Buntari Agustini, Department of Nursing, Faculty of Health, Institute of Technology and Health Bali, Indonesia.
Email: incaagustini@gmail.com

Key words: palliative care; palliative care nurses; phenomenology.

Contributions: II, research design, data collection, data analysis, and writing original draft; NLPIBA, study conception, data collection, manuscript writing; IKS, review and editing.

Conflict of interest: the authors have no conflict of interest to declare.

Ethics approval and consent to participate: the research has received ethical approval from the Health Research Ethics Committee of the Bali Mandara Regional General Hospital, Bali Province (No. 066/EA/KEPK.RSBM.DISKES/2024). During the research, the researchers paid attention to the ethical principles of informed consent, respect for human rights, beneficence, and non-maleficence.

Consent for publication: written informed consent was obtained for anonymized patient information to be published in this article.

Availability of data and materials: all data generated or analyzed during this study are included in this published article.

Funding: this study was funded by the Directorate of Higher Education, Ministry of Education and Culture of the Republic of Indonesia; Directorate of Research, Technology and Community Service (DRTPM), with master contract number 110/E5/PG.02.00.PL/2024; derivative contract number 2927/LL8/AL.04/2024; DL.02.02.2361.TU.VI.2024.

Acknowledgments: the research team would like to thank Bali Mandara Hospital's leadership and the nurses involved. We also express our gratitude to the patients and families who participated in this research.

Received: 18 November 2024.
Accepted: 3 March 2025.
Early access: 15 April 2025.

Healthcare in Low-resource Settings 2025; 13(s1):13398
doi:10.4081/hls.2025.13398

Introduction

Palliative care is a type of healthcare service that focuses on providing care to patients with terminal illnesses to maintain their quality of life.[1] Palliative care patients have very complex health problems and require special attention, including physiological, psychological, social, spiritual, cultural, and existential problems.[2] Cultural diversity in palliative care practices is a challenge and an interesting issue to pay attention to.[3] Complex cultural issues can influence the progression of the disease, the effectiveness of treatment, and the satisfaction of patients and families with palliative care services.[4]

Palliative care has become a national health service policy in Indonesia.[5] However, the progress of palliative care service practices still varies and continues to develop in each region. The success of implementing palliative care is affected by patient perceptions, the limited availability of caregivers, and national standards of palliative care that are not yet widely accessible. Hospitals that are dedicated to considering culture in applying effective palliative care principles and practices will find it easier to achieve success in palliative care.[6,7]

Key factors for an effective palliative nursing care model include social, economic, and cultural dimensions that significantly impact patients' quality of life.[8] Cultural determinants are among the aspects of palliative care that have been less extensively researched.[1] Understanding culture helps nurses see how it influences patients' health and can support their well-being.[9,10]

Despite the critical role of culture in influencing palliative care outcomes, structured frameworks that integrate cultural considerations into nursing models in hospital settings are lacking. The research and development of palliative nursing practices from a cultural perspective are important for enhancing collaboration among patients, families, and communities, facilitating the identification and negotiation of culturally significant care to improve

patients' quality of life and ensuring palliative nursing practices align with community needs.[11] This study aimed to determine pivotal factors to consider when developing a culture-based palliative nursing care model in hospitals.

Materials and Methods

Research design

This study employs a qualitative design with a phenomenological approach to analyze the experiences of patients, nurses, and families of palliative care patients, aiming to recommend the development of a culture-based palliative nursing care model in hospitals.

Participants and sampling

The study included 11 participants comprising nurses, palliative care patients, and their families, aligning with the criteria for phenomenological research.[12] Sampling utilized a purposive technique, selecting participants among nurses who directly cared for palliative care patients, individuals diagnosed with conditions requiring palliative care, and the families of these patients. All participants had a good cooperative attitude, were willing to participate, and were actively involved until the end of the group discussion session.

Data collection and instruments

Data collection was conducted using the face-to-face Focus Group Discussion (FGD) method. Participants were divided into three groups: the nursing discussion group, the patients' discussion group, and the family discussion group. Focus group discussions were conducted separately at different times and places. Data collection was conducted at Bali Mandara General Hospital, Bali Province. No other parties were involved in the discussion besides the participants, who had been selected based on the inclusion criteria. The FGDs lasted for one to nearly two hours, as the participants displayed significant enthusiasm for the discourse. All participants remained present for the entirety of the session. The research instruments used were FGD guidelines, notebooks, and voice recorders. The research instruments were supplied by the research team and evaluated to confirm that the questions in the FGD could yield substantial information to address the study's objectives. The FGD questions encompassed the patient's experience as a palliative care recipient, the family's feelings and support for these patients, the nurses' roles in palliative care, and the perspectives of each FGD group regarding the factors contributing to the efficacy of palliative care. The FGD data were transcribed and verified for accuracy and validity.

Data analysis

The research data were analyzed using a thematic analysis approach with the Colaizzi approach[13] without software. Nurse participants were coded "PN", patient participants were coded "PP", and family participants were coded "PF".

Ethical clearance

This study was conducted at the Bali Mandara Regional General Hospital, Bali Province, in October 2024, with an ethical clearance letter from the Health Research Ethics Committee of the Bali Mandara Regional General Hospital, Bali Province, No. 066/EA/KEPK.RSBM.DISKES/2024.

Results

The participants were aged 29-44 years, with the lowest education level being junior high school and the highest a bachelor's degree. The sample included one male nurse (PN1), four female nurses (PN2, PN3, PN4, PN5), one male patient (PP1), two female patients (PP2, PP3), one male family member (PF1), and two female family members (PF2, PF3) (Table 1).

In developing a culture-based palliative care model in hospitals, five important themes — patient conditions, family support, nurses' roles, service policies, and cultural influence — and subthemes must be considered (Table 2).

Theme 1: patient condition

This theme centers on patient conditions and the creation of a palliative nursing care model. Additionally, it will highlight crucial considerations for nurses when assessing the conditions of palliative care patients.

Subtheme 1: knowledge

The patient's level of knowledge about the disease is related to the speed of diagnosis, treatment program, and worsening of the condition.

"*Our experience is that low patient knowledge makes the disease worse because of late treatment.*" (PN2)

Table 1. Participant characteristics (n=11).

No.	Age (years)	Gender	Education level	Status	Code
1	32	Male	Bachelor's Degree	Nurse	PN1
2	39	Female	Bachelor's Degree	Nurse	PN2
3	32	Female	Bachelor's Degree	Nurse	PN3
4	33	Female	Bachelor's Degree	Nurse	PN4
5	28	Female	Diploma III	Nurse	PN5
6	32	Male	Senior High School	Patient	PP1
7	56	Female	Junior high school	Patient	PP2
8	41	Female	Bachelor's Degree	Patient	PP3
9	44	Male	Senior High School	Family member	PF1
10	35	Female	Bachelor's Degree	Family member	PF2
11	29	Female	Senior High School	Family member	PF3

"*I never thought my illness would last this long.*" (PP2)

"*Previously we didn't know about this disease, and didn't expect it to be like this.*" (PF3)

Subtheme 2: psychological challenges

The psychological issues encountered by palliative care patients exhibit significant complexity, leading to feelings of helplessness, entitlement, apathy towards treatment, fatigue, sadness, and a sense of undervaluation by their families.

"*...tendency to be psychological, so lazy to seek treatment, no longer enthusiastic, sometimes spoiled, sometimes feel no longer appreciated by the family, there are even patients who cry.*" (PN1)

"*I feel shocked and can't do anything.*" (PP1)

"*Tiring, have no choice but to continue*." (PP3)

Subtheme 3: education

The patient's level of education is related to their readiness to receive and understand information. Patients with a high level of education are more open to information, enthusiastic about seeking information, and have a better quality of life. Meanwhile, patients with a low level of education tend to be closed, dishonest, and usually prioritize alternative medicine.

"*There is a gap between patients who have a high and low educational background. Experience shows that the patient's readiness to receive information provided by the nurse is different*." (PN3)

"*Patients who have a good level of education are usually more open, enthusiastic about asking questions, and have a better quality of life, while patients who have low education are usually closed, dishonest, and usually go to alternative medicine first and then come in severe condition*." (PN5)

Subtheme 4: age

Young patients have high hopes for recovery and influence their families to have the same hopes. Older patients tend to be more accepting of their illness, and so do their families.

"*Usually, young patients have more enthusiasm to recover, while older patients, generally over sixty years old, often have families who accept the situation*." (PN1)

"*Some patients who are still in the productive age usually have very high hopes for health even though sometimes the condition of the disease is already in the final stage.*" (PN5)

Theme 2: family support

This theme emphasizes the significance of diverse familial supports in developing palliative nursing care model. It will show nurses the different aspects that must be considered in the families of palliative care patients who will become the patient's primary caregivers.

Subtheme 1: psychological state

Families of palliative care patients face complex psychological challenges, such as burden and fatigue.

"*The tendency for patients to become spoiled can eventually burden the family, as the patient may sulk at them despite the family's constant help*." (PN1)

"*When the patient starts to sulk or get angry, usually the family members start to have headaches, and their psyche is disturbed*." (PN4)

"*The family also feels hurt because of the extra effort, such as time and costs*." (PP2)

Subtheme 2: knowledge

Family knowledge is related to the ability to receive and understand the information provided. Therefore, it is very important to assess the level of knowledge of the family of palliative care patients.

"*My experience from the family's perspective is how the family receives communication, education, and information from hospital services, and how they can accept it or not*." (PN2)

"*The family must also serve as anamnesis, particularly regarding their understanding of the patient's illness and treatment*." (PN1)

Subtheme 3: communication

The patient's health condition and treatment program are primarily conveyed to the immediate family, who are responsible for making decisions concerning their care.

"*We typically communicate or convey information to the nuclear family, as we believe they are the ones who can make decisions.*" (PN4)

"*Not only the nuclear family but also distant families also take part in making decisions*." (PN3)

Subtheme 4: assistance

Family assistance is very much needed by patients during the treatment program. Family support is related to patient calmness, increasing patient happiness, reducing anxiety, and reducing stress.

Table 2. Overview of themes and subthemes.

Theme	Subtheme
Patient condition	Knowledge Psychological challenges Education Age
Family support	Psychological state Knowledge Communication Assistance Economic status
Role of nurses	Advocacy Education Caring attitude Helping with ADL Realistic expectations
Health service policies	No code blue Supportive therapy Entertainment Availability of resources Teamwork Chemotherapy services Health insurance
Cultural influence	Spiritual needs Fear of death Desire not to die at home Internet use Alternative medicine

Families who are busy with work can arrange alternating schedules to accompany patients during the treatment program.

"*How often do they accompany the patient to help keep them calm?*" (PN3)

"*The accompanying family members usually change because they work. The patients are happy to have family accompanying them*." (PN2),

"*There is a family who faithfully accompanies the patient during consultations with doctors and listens to the doctor's advice*." (PN5)

"*I accompany and comfort patients so that they are not stressed and depressed with their current illness and condition*." (PF2)

"*I have a shift to be with my mother during chemotherapy. Sometimes when my mother returns from chemotherapy, I also take care of her because after chemotherapy, her condition sometimes drops*." (PF3)

"*My family is good, always supports me and asks about what actions to take next and is always by my side*." (PP1)

"*My family's role is very important*." (PP3)

Subtheme 5: economic status

The economic status of patients and families is related to the speed of decision-making. Patients from families with low financial status tend to be slower in making decisions, and the patient's condition becomes worse.

"*Patients from families with a good economy usually find it easier to accept information, and decisions about treatment and care are easier, while patients from families with a poor economy usually only listen and make decisions when their complaints are very severe*." (PN2)

Theme 3: role of nurses

This theme focuses on the critical role of nurses in developing a palliative care model.

Subtheme 1: advocacy

Nurses serve as patient advocates, acting as a bridge between the needs of patients and families and the doctors responsible for the patient's treatment program. Nurses also act as mediators among families when there are differences in understanding information and differing opinions about the patient's condition and treatment plan.

"*We act as a mediator when problems or differing opinions arise between the patient and their family, serve as a director to control the patient's needs during treatment, and advocate for the patient with the doctor.*" (PN1)

"*We act as a bridge between patients and doctors. There are some things that patients want to tell the doctor but don't have time, so we as nurses will help convey what the patient feels*." (PN5)

Subtheme 2: education

Nurses educate patients about treatment timelines, examination appointments, and necessary preparations for patients and their families.

"*Communication between nurses and patients is very important, it is a nurse's medium for patient preparation during hospitalization, preparation for going home, or for home care*." *(PN2)*

"*We inform the patient when they should come back for treatment and check-ups, as well as what they need to do to prepare for that.*" (PN5)

Subtheme 3: caring attitude

The caring attitude of nurses is related to the patients' and families' satisfaction with receiving health support from nurses. The caring attitude of nurses is shown by the nurse's smile, joking attitude, friendliness, humility, and responsibility in their work.

"*The more we can show an empathetic attitude and empathetic body gestures, both to patients and families, the more it can provide a kind of support for the patient's condition and the condition of the family who cares for them*." (PN2)

"*Not showing a face that is too serious, but smiling and joking, in my opinion, that's one of the ways to get closer and more familiar with patients so that they are more enthusiastic*." (PN5)

"*All nurses are good and responsible, also friendly*." (PF1)

"*Very helpful and work with full responsibility*." (PF2)

"*Good nurses, friendly and always provide supportive advice*." (PP1)

"*Nurses who care with heart, and that is the most important*." (PP2)

Subtheme 4: help with activities of daily living (ADL)

Nurses help patients meet their daily living needs when there is no family or companion to rely on. The fulfillment of patients' daily living needs by nurses includes assisting with feeding, bathing, and washing hair.

"*If no family is accompanying, we help with the patient's needs, such as helping to feed*." (PN1)

"*That is typically what we do to help patients, such as bathing and washing their hair.*" (PN2)

Subtheme 5: realistic expectations

Nurses do not set certain expectations for patients and families. This is important to prevent excessive hope. Nurses inform patients and families about the patient's current condition and potential future outcomes, and they communicate all available treatment options designed to assist patients.

"*We communicate the truth about the patient's condition and life expectancy so that the patient and family understand and do not expect anything more than the patient's initial condition*." (PN1)

"*We tell patients and families what the maximum treatment and care is like, especially to terminal patients, so that patients and families do not have excessive expectations.*" (PN5)

Theme 4: health service policies

This theme focuses on service aspects that can support the development of a palliative nursing care model.

Subtheme 1: no code blue

The variable status of palliative care patients renders the code blue policy inapplicable. Palliative care patients with deteriorating conditions continue to receive emergency treatment as per established protocols but are no longer assigned a code blue.

"*Starting this month, deteriorating palliative care patients are not given a code blue. They are still resuscitated in the room, but a code blue will not be called*." (PN3)

"*If the condition is bad, now the code blue is no longer used for palliative care patients.*" (PN5)

Subtheme 2: supportive therapy

Supportive therapy is given not to cure the disease but to relieve symptoms and reduce suffering for the patient.

"*The therapy provided is typically maximal, which means that the only additional treatment available is supportive therapy. For example, painkillers are administered if there is pain*." (PN3)

"*Palliative care patients here usually receive supportive therapy such as medication to reduce pain and various symptoms so that they can carry out daily activities*." (PN5)

Subtheme 3: entertainment

Palliative care patient entertainment services are very important to maintain the psychological health of patients during treatment. Entertainment services can be provided in groups with singing, karaoke, and dancing activities.

"*To maintain the psychological health of our patients, we usually provide entertainment media, we hold "sarasehan". Sarasehan refers to a gathering of patients in the hall where they can participate in karaoke entertainment, singing, dancing, and counseling*." (PN1, PN2).

Subtheme 4: availability of resources

The constraints faced by palliative care nurses, who are responsible for patient monitoring, necessitate that other nursing professionals caring for palliative patients engage in self-directed learning. This development happens through socialization with palliative care nurses, participation in webinars, and direct consultation with palliative doctors.

"*Only one nurse has undergone palliative training. Though still limited, we benefit from socialization, participate in webinars, and have more direct consultations with palliative doctors*." (PN2, PN4).

Subtheme 5: teamwork

Good teamwork is related to the speed of handling palliative care patient cases. The main teamwork is between doctors and nurses. Palliative doctors dedicate ample time for communication and consultation with nurses whenever necessary, entrusting them to handle patients needing immediate treatment without waiting for a doctor's presence for the patient's benefit. All of this is effectively communicated through teamwork.

"*We can disturb all the doctors at any time. We contact them as if there are no working hour limits. Doctors also trust nurses and do not hesitate to involve them in important actions that are communicated for their patients' sake*." (PN5)

"*Palliative care patients usually re-enter the ER. Nurses typically inform the palliative care nurse when another palliative care patient arrives in the ER. The ER nurse's service operates as usual, responding only to complaints and not including any special services*." (PN5)

Subtheme 6: chemotherapy services

The availability of chemotherapy facilities for cancer patients is very helpful in improving their health status. Chemotherapy services have successfully reduced the tumor size and expedited the advanced stage of treatment necessary for surgical procedures.

"*My husband was treated here, and there has been a change. Now it has improved because there is chemotherapy*." (PF1)

"*Now the lump has not grown again, and my mother has undergone the fourth chemotherapy*." (PF2)

"*More or less six chemotherapies, then the doctor said she could have surgery. Yesterday, after consulting with the doctor, the results of the laboratory examination were good, and after the sixth chemotherapy surgery could be performed*." (PF3)

Subtheme 7: health insurance

BPJS (*Social Security Agency on Health*) is an Indonesian health insurance program that has supported many palliative care patients in their treatment plans. The existence of BPJS facilities is beneficial for patients and families in financing treatment.

"*This hospital accepts patients with BPJS insurance, so we are grateful that because we have BPJS insurance, we don't have to pay for treatment costs*." (PP1)

"*Coincidentally, my mother uses BPJS, there is nothing to pay. This is very helpful, helpful.*" (PF2)

Theme 5: cultural influence

This theme focuses on cultural aspects that are of concern in developing a palliative nursing care model.

Subtheme 1: spiritual needs

The availability of clergy in hospitals is needed for patients who need prayer support to gain better spiritual strength.

"*We prepare clergy and inform patients and families that if they are in critical condition and need clergy, we already have them available. We then contact the clergy to arrange prayer services for those patients.*" (PN2)

"*Always ask for prayers from the clerics to be given strength and healing*." (PP2)

Subtheme 2: fear of death

Fear of death is a significant experience for patients and families that nurses need to understand. It takes time for patients and their families to process the situation and for families to prepare for the death of a loved one.

"*Most still tend to be afraid of dying. The family will do anything so that the patient can survive, even though they know that the patient is at the final station. There is a fear of being abandoned and leaving the family*." (PN3)

Subtheme 3: desire not to die at home

Not wanting to die at home is a culture in this region. Dying at home is considered a failure for the family in caring for palliative care patients.

"*If possible, the patient is treated longer and dies in the hospital. The patients should not die at home because if they die at home, the community usually thinks the family was unable to care for them*." (PN4)

Subtheme 4: Internet use

Using Google as a search engine is one way for patients and families to find answers and good guidance for what they need.

Unfortunately, misinterpreting information that does not align with the patient's condition can be a challenge for nurses.

"*Especially now, patients' families are playing around with Google, googling a little bit and saying that the family should still be alive, they should be treated in the ICU, and so on, based on what they read on Google*." (PN4)

"*With technology, we can search online to learn about the disease and what chemotherapy is like.*" (PF2)

"*Google is very helpful if I have questions*." (PF3)

"*I sometimes search on Google for the causes and prevention*." (PP1)

Subtheme 5: alternative medicine

The use of alternative medicine is related to delays in medical treatment, which results in worsening patient conditions. Patients tend to choose alternative medicine and shamans and ignore medical treatment.

"*Taking traditional medicine as people suggest, hopefully, you will recover*." (PP1)

"*Some patients are more inclined to alternative medicine, smart people, herbal concoctions, ignoring medical treatment. Then they don't get good results, then they seek medical treatment and are already in a serious condition*." (PN5)

Discussion

The condition of palliative care patients is an important aspect that forms the basis for developing a nursing care model. Patients requiring palliative care must be properly identified, as this is necessary for receiving effective palliative care.[14,15] There are still palliative care patients who have low levels of knowledge and have wrong information about palliative care, highlighting the need for better health education.[16] The age of the patient is an important factor to consider in palliative care; in comparison to younger patients, older patients are more accepting of their condition and expect less palliative care to prolong their lives.[17]

Moreover, palliative care patients often experience severe psychological issues and require effective support to enhance their comfort, psychological well-being, and resilience, ultimately improving their quality of life.[18] Family support greatly improves the palliative care process, allowing patients to cope with their challenges more effectively. Family support encompasses various dimensions, including informational support, whereby the family is required to comprehend the patient's health condition and offer guidance regarding health matters; instrumental support, which pertains to the family fulfilling the financial requirements associated with the patient's treatment process; and emotional support, which includes elements of self-esteem and companionship that contribute to the patient's happiness and motivation.[2] The active involvement of the family in caring for patients with respectful, clear, and culturally appropriate communication will provide emotional strength so that patients can undergo better treatment and care.[18] However, it is important to consider that families may also face significant emotional challenges stemming from the impact of the disease on their relatives' emotional well-being.[19]

Along with family support, nurses who have a positive attitude toward palliative care can influence quality services and improve patients' quality of life.[20] The role of nurses serves as a crucial starting point for the healthcare team to consider various factors, including culture.[1,21] Nurses, as providers of palliative health services, play a fundamental role in understanding the cultural assumptions that influence patients' decision-making, fostering open communication with families, and identifying what best meets their expectations during their treatment.[3] Additionally, nurses delivering palliative care must recognize that instilling hope in patients should be grounded in realism to assist patients and families in accepting their circumstances and preparing for a dignified death.[22] Therefore, improving the understanding and skills of nurses is very important to enhance the quality of palliative care services.[6] Nurses who underwent palliative care training had significantly more positive attitudes toward palliative care than those who did not receive such training.[20] Education about palliative care has proven effective in increasing nursing students' knowledge, attitudes, comfort, and self-awareness regarding the importance of palliative care in health services. Palliative care education and practice should continue to evolve and be integrated into nursing schools to help nursing students understand early on that palliative care is a vital competency they must achieve.[23] As patient advocates, nurses play a role in safeguarding information that should not be disclosed to others or anyone claiming to be the patient's family without the patient's consent.[24]

This study found that current hospital policies no longer announce code blue signs for palliative care patients, but medical services and care are still carried out. Code blue often comes from palliative units, where patients have long-term diseases. The main purpose of palliative patient care is to assist patients in living their lives and accepting death with dignity.[25] A code blue situation in a hospital is a highly stressful event for everyone involved and profoundly impacts the emotional well-being of patients and their families. Regardless of the results, code blue can be traumatic for palliative care patients and their families if it occurs repeatedly after the worsening of the patient's condition.[26] Besides that, emergency services, as the main unit for handling code blue, are very busy, noisy, and not an optimal environment for palliative care patients. Consequently, hospital policies need to consider the special role of the emergency unit in managing palliative care.[27]

Another essential aspect of palliative care is entertainment. Music therapy or singing for palliative care patients can overcome emotional problems, improve social relationships, and improve patient comfort.[28]

The restricted availability of qualified human resources in the realm of health care specializing in palliative services necessitates robust advocacy directed toward policymakers to increase the number of skilled palliative care professionals within public health.[29]

Ownership of health insurance, such as BPJS, serves to safeguard patients and their families against the adverse financial repercussions associated with medical care expenses. Furthermore, possessing health insurance ensures that patients receive equitable healthcare services.[30] Affordable access and complete facilities available at health facilities will be able to increase public awareness to utilize health services as the main place to obtain treatment and services that meet expectations.[31]

Culture is a constellation of societal beliefs and behaviors that shape the patient's identity as part of a community group. Unique cultural backgrounds are important to assess and accommodate properly because they can affect the disease process, the success of health care, and the patient's ability to make decisions.[32] Clergy leaders can influence patients and families to obtain spiritual peace according to their religion. Spiritual care has been widely proven to increase patient comfort and patient acceptance of illness in palliative care.[33] Fear of death is common in palliative care patients,

both young and elderly. However, it can be reduced with maximum comprehensive nursing in a special palliative care unit.[34] Passing away at home is often deemed unexpected, as it is perceived as a failure of the family to provide adequate care for their relatives. Determining the place of death and who to accompany are important aspects that should be considered in the process of assessing culture-based palliative nursing care.[35]

Searching for information on the internet has had an impact on increasing anxiety in palliative care patients because they get inappropriate information. The lack of optimal information from health service providers generally influences information-seeking behavior online.[36] Therefore, nurses are expected to be able to develop pocketbooks or modules as a clearer and more precise medium for information and health education for patients and families in order to reduce anxiety due to limited access to information. The material presented must also adopt a cultural approach, ensuring that patients and families feel respected in accordance with relevant cultural aspects.[37] Alternative and complementary medicine includes various treatments, herbs, diets, and physical therapies typically not considered in conventional therapies. Alternative medicine is the patient's choice, often disregarding medical treatment. Those using alternative medicine should be aware of potentially dangerous side effects, interactions with other therapeutic drugs, delays in the diagnosis process by doctors, and the possibility of impacting timely medical treatment.[38]

In the coming years, palliative care should focus on community and family needs, emphasizing the external factors that enhance its effectiveness after hospital discharge. This includes acknowledging patient choices to pursue alternative therapies while not adhering to traditional medical practices. Community nurses and primary care providers play a crucial role in delivering ongoing home-based or community-centered palliative care to patients.[8] A culturally safe, community-based care approach will contribute more positively to enhancements in comprehensive palliative care services.[18]

Clinical implications

The findings of this study highlight the significant clinical effectiveness of nursing assessment, intervention, and implementation of culture-based palliative care in hospitals. Key nursing assessments involve patient age, education level, knowledge level, psychological issues, economic status, health insurance coverage, use of alternative medicine, and the desire to die at home. Key components of nursing intervention and implementation include communication with patients and families, providing family support, advocating for patients and families, educating patients and their families, maintaining a caring attitude, assisting patients with ADL, offering hope, avoiding code blue situations, delivering supportive therapy, facilitating entertainment, ensuring the availability of patient care resources, collaborating as a team, providing chemotherapy services, addressing spirituality, and developing internet-based information systems.

This study has limitations, including the lack of religious or cultural figures and stakeholders as informants for obtaining service leadership recommendations. However, it could help researchers identify important factors to consider when developing a culture-based palliative nursing care model in hospitals. Engaging stakeholders as experts in evaluating the developed palliative nursing care model is a significant step for the future.

Conclusions

This study underscores significant experiences in palliative care, focusing on patient age, psychological factors, educational background, and knowledge acquisition. The support of family members, effective communication, assistance, and economic status are of paramount importance. Nurses assume a crucial role as advocates and educators, balancing care with realistic expectations. Additionally, health facility policies regarding code blue protocols, supportive therapies, recreational activities, human resource allocation, teamwork, chemotherapy protocols, and insurance matters are essential components. Cultural considerations, such as the involvement of clergy, apprehension surrounding death, internet utilization, and preferences for alternative medicine, significantly impact the quality of care provided. These insights serve as a valuable foundation for developing a culture-based nursing model, highlighting the necessity of stakeholder engagement to enhance future palliative care initiatives.

References

1. Monette EM. Cultural Considerations in Palliative Care Provision: A Scoping Review of Canadian Literature. Palliat Med Reports 2021;2:146-56.
2. Witjaksono AMAL, Maulina VVR. Gambaran Perceived Social Support Pada Penderita Kanker Stadium Lanjut yang Menjalani Perawatan Paliatif. J Psikogenes 2016;4:12-24.
3. Six S, Bilsen J, Deschepper R. Dealing with cultural diversity in palliative care. BMJ Support Palliat Care 2023;13:65-9.
4. Senel G, Silbermann M. Cultural challenges in implementing palliative programs in emerging countries. Palliat Med Hosp Care Open J 2017; available from: https://www.researchgate.net/publication/318889762_Cultural_Challenges_in_Implementing_Palliative_Programs_in_Emerging_Countries
5. Rochmawati E, Saun AU. Effectiveness of symptom management training on caregiving preparedness and burden of family caregivers in-home palliative care: a quasi-experimental study. J Ners 2022;17:153-60.
6. Tampubolon NR, Fatimah WD, Hidayati AUN. Hambatan-Hambatan a Implementasi Perawatan Paliatif di Indonesia: Systematic Review. J Kesehat 2021;14:1-10.
7. Bruera E. The development of a palliative care culture. J Palliat Care 2004;20:316-9.
8. Van Heerden EM, Jenkins LS. The role of community health workers in palliative care in a rural subdistrict in South Africa. African J Prim Heal Care Fam Med 2022;14:1-9.
9. Leininger M, McFarland MR. Transcultural Nursing; consepts, theories, research & practice. Third Ed. Vol. 148. by The McGraw-Hill Companies, Inc; 2002.
10. Agustina R, Fetzer SJ, Lai WS, et al. ABCDE assessment for palliative care truth-telling dilemmas: a case study. Int J Palliat Nurs 2024;30:444-50.
11. Cain CL, Surbone A, Elk R, Kagawa-Singer M. Culture and Palliative Care: Preferences, Communication, Meaning, and Mutual Decision Making. J Pain Symptom Manage 2018;55:1408-19.
12. Creswell JW, Creswell JD. Research Design Qualitative, Quantitative, and Mixed Methods Approaches. Fifth Ed. SAGE Publications, Inc. 2018.
13. Praveena K.R, Sasikumar S. Application of Colaizzi's method

of data analysis in phenomenological research. Med Leg Updat 2021;21:914-8.
14. Pham L, Arnby M, Benkel I, et al. Early integration of palliative care: translation, cross-cultural adaptation and content validity of the Supportive and Palliative Care Indicators Tool in a Swedish healthcare context. Scand J Caring Sci 2020;34:762-771.
15. Rettobyaan F, Widodo B. Palliative management of a patient with gastric outlet obstruction (GOO) due to caput pancreatic cancer during COVID-19 pandemic. Bali Med J 2023;12:744-8.
16. Atena D, Imane B, Maryam R, et al. The level of knowledge about palliative care in Iranian patients with cancer. BMC Palliat Care 2022;21:33.
17. Parr JD, Zhang B, Nilsson ME, et al. The influence of age on the likelihood of receiving end-of-life care consistent with patient treatment preferences. J Palliat Med 2010;13:719-26.
18. Redondo Elvira T, Ibáñez del Prado C, Cruzado JA. Psychological well-being in palliative care: A systematic review. Omega (United States) 2023;87:377-400.
19. Schill K, Caxaj S. Cultural safety strategies for rural Indigenous palliative care: A scoping review. BMC Palliat Care 2019;18:21.
20. Getie A, Ayalneh M, Aytenew TM, et al. Attitude of nurses towards palliative care and its associated factors in Ethiopia, systematic review and meta-analysis. BMC Palliat Care 2024;23:67.
21. Indarwati R, Fauziningtyas R, Jalaludin NS, et al. The factor of resident safety culture in nursing homes in Indonesia. Work Older People 2023;27:91-8.
22. Laranjeira C, Dixe MA, Semeão I, et al. "Keeping the Light on": a qualitative study on hope perceptions at the end of life in Portuguese family dyads. Int J Environ Res Public Health 2022;19:1561.
23. Ulfiana E, Has EMM, Rachmawati PD. The Development of Palliative Community Health Nursing to Increase Family's Autonomy in Caring Patient with Cancer At Home. J Ners 2013;8:309.
24. Testoni I, Wieser MA, Kapelis D, et al. Lack of truth-telling in palliative care and its effects among nurses and nursing students. Behav Sci (Basel) 2020;10:88.
25. Uludag O, Dogukan M, Duran M, et al. Code blue practice in patient safety: Single center retrospective evaluation. Ann Med Res 2019;26:1922.
26. McWhirter M, Heikkinen P, Dérissé G, Mehta AK. Specialty Palliative Care in a Code Blue: An Unexpected Role. J Palliat Med 2022;25:1747-50.
27. Lawrenson R, Waetford J, Gibbons V, et al. Palliative care patients' use of emergency departments. N Z Med J 2013;126:80-8.
28. Clements-Cortés A. Singing and Vocal Interventions in Palliative and Cancer Care: Music Therapists' Perceptions of Usage. J Music Ther 2017;54:336-61.
29. Putranto R, Mudjaddid E, Shatri H, et al. Development and challenges of palliative care in Indonesia: Role of psychosomatic medicine. Biopsychosoc Med 2017;11:1-5.
30. Akarowhe K. Benefits of implementing health insurance policy in developing countries for a better palliative care. J Palliat Care Med 2018;08.
31. Israfil I, Yusuf A, Efendi F, et al. Exploring the primary health facility availability, health control, drug consumption, and healthy living behavior among patients with hypertension. Healthc Low-resource Settings 2024;12:11867.
32. Becker TD, Cagle JG. The Importance and Impact of Culture in Palliative Care. In: Terry Altilio Shirley Otis-Green JGC, editor. The Oxford Textbook of Palliative Social Work. Oxford University Press; 2022. pp. 1-24.
33. Gijsberts MJHE, Liefbroer AI, Otten R, Olsman E. Spiritual Care in Palliative Care: A Systematic Review of the Recent European Literature. Med Sci (Basel, Switzerland) 2019;7:15-7.
34. Tsai JS, Wu CH, Chiu TY, et al. Fear of death and good death among the young and elderly with terminal cancers in Taiwan. J Pain Symptom Manage 2005;29:344-51.
35. Hoare S, Morris ZS, Kelly MP, et al. Do patients want to die at home? A systematic review of the UK literature, focused on missing preferences for place of death. PLoS One 2015;10:e0142723.
36. Beekers N, Husson O, Mols F, et al. Symptoms of anxiety and depression are associated with satisfaction with information provision and internet use among 3080 cancer survivors: results of the PROFILES registry. Cancer Nurs 2015;38:335-42.
37. Israfil I, Yusuf A, Efendi F. Effectiveness of A Health Behavior Module Based on Transcultural Nursing in Efforts to Prevent Cardiovascular Complications on Hypertension Patients in the Community. Indones J Glob Heal Res 2024;6:1293-302.
38. Martin JH, Patel J. Complementary and alternative therapies in the palliative setting. Intern Med J 2022;52:1677-84.