E – International Scientific Research Journal, VOLUME – V, ISSUE – 3, 2013, ISSN 2094 - 1749

Palliative Care Rendered by Clinical Nurses: Basis for Proposed Program Development

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INTRODUCTION

Advanced health knowledge, technology, and management approaches made man's life longer. Along with this longer lifespan is a range of chronic and complex illnesses that are life limiting which may require admission to a hospital or residential care facility for management. It is in this point that palliative approach has much to offer to patients and families. Throughout this approach are challenges to the role of nurses in providing holistic care to dying patients and their families.

The World Health Organization (WHO) first defined palliative care in the early 1990s. The focus of care then was undoubtedly cancer, however the WHO has updated the definition to encompass all life-limiting conditions (Kinghorn & Gains, 2007), defined palliative care 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, psychosocial and spiritual.

The care of a sick member of a family is a tradition established in the Philippines family health care. However, when terminally ill patient is being cared for, the members of the family would hide from the patient the gravity of his illness and the impending danger of his death. The family members continue to feed hope to the patient that he would recover from his sickness. On the other hand, there are cases when a patient knows that he is dying but in his desire not to alarm the family, he refrains from discussing the state of his health with family members.

There is a cultural and emotional barrier that prevents an open discussion of death and dying and other end of life issues between the patient and the family members. Without proper guidance and support, family members would oftentimes bring patients to hospitals for the latter to handle the dying patient because they do not know or have not been taught or afraid to handle death in their homes. In most cases there are no advance directives given by patients and or relatives on medical decisions that have to be made at the end of life most especially if the patient is a child or young. In this setting, the family and the patient are caught unprepared for death because they purposely erased death from their consciousness. There is denial of death and avoidance of pain. Hence, the family is not equipped to handle death when it comes.

As the patient and their families think about the many losses caused by the illness, they begin to experience grief. The family afflicted with grief has to deal with the financial cost of dying, the arrangements for the wake and burial and most of all to resolve personal and other end of life issues between the patient and the family.

The process of grief starts with diagnosis of the illness when there is potential loss of the future, and continues for the patient until he dies. For the family who will be left behind, the grief continues into their bereavement.

Sometimes patients and their families meet the health care team during the last few days or even hours of life and there is a very short time in which to get to know the family. This makes building the relationship a challenge, as a sensitive caring approach can be very healing and make a difference to the family during their bereavement (Kinghorn and Gains, 2007).

Among members of the health care team, nurses are the one who got extensive degree of challenge in taking care of patients who are nearly to die, patients who are referred for palliative care, when treatment is no longer possible.

Since goal is the guide to reach the end point or achievement of the task which is quality of life of patients facing life threatening disease or death, palliative care nurses should provide physical, psychological, social, spiritual cultural ethical and grief support. It is in this background that the research will explore the extent of palliative care rendered by clinical nurses to their patients and significant others for the quality of life.

The researchers believe that part of being a competent palliative care nurse is being emotionally and spiritually prepared. Through this study, the clinical instructors may re-emphasize to their students the importance of end of life care for them to have a better understanding and appreciation of it; may enhance the existing program in nursing education about palliative care. The health care system can have more competent nurses who are ready to face the challenges of this special and heart-warming part of nursing. Therefore, patient will have a relaxed, peaceful and meaningful life even they face an end-to-life stage.

Objectives of the Study

The study sought to determine the extent of palliative care rendered by the clinical nurses to the patients who have acute, serious life-threatening illness and progressive chronic illnesses. Specifically, it aimed to determine the profile of the respondents in terms of gender, age, highest educational attainment, family monthly income, diagnosis, length of time had been diagnosed and the current medical/nursing management; determined the extent of palliative care provided by the clinical nurses in terms of physical, psychological, social, spiritual, cultural, and ethical aspects; tested the hypothesis if there is significant difference between the responses of the patient and significant others / relatives to the extent of palliative care provided by the clinical nurses; determined the significant difference on the extent of palliative care rendered when grouped according to profile variables. Lastly, proposed a program that will enhance palliative care rendered.

Theoretical Framework

One of the nurse's roles is being a care provider who performs comforting actions for a patient. According to Kolcaba's comfort theory (2003), patients experience comfort needs in stressful health care situations. Patients and their families/support groups meet some needs but other needs remain unmet. These needs can be identified by a nurse who then implements comfort measure to meet the needs. Enhanced comfort readies the patient for subsequent healthy behaviors or a peaceful death. Comfort measures can provide relief, help ease a distress or help support the patient to transcend the experience or condition.

Comfort needs are assessed in four context of patient's experience: a) physical, which pertains to bodily sensation and physiological problems associated with medical diagnosis, b) psychospiritual which pertains to the internal awareness of self, including esteem, concept of sexuality, and meaning in one's life (this can also encompass one's relationship to a higher order or being), c) environmental which is for the external background of human experience, encompass light, noise, ambiance, color, temperature, and natural versus synthetic elements, d) social pertains to interpersonal, family and societal relationship.;

Types of care emphasized in this theory: technical which is rendered through administering pain relief, positioning and monitoring; coaching through relieve anxiety, provide information, instil hope, and plan for recovery; comforting which is for making patients/families feel cared for, strengthened and connected.

In relation to the study, the variables identified such as the profile of the patient, the extent of palliative care rendered according to the different aspects and the responses of both patients and relatives to the care rendered by the nurse are identical to the Kolcaba's theory of comfort as to the comfort needs of the patient and the types of care to be provided as an answer to the identified needs.

Providing comfort is definitely one of the nurse's domains of service and care. Nurses are the ones in direct contact with their patients, providing relief from certain discomfort; continuously assessing, monitoring and providing care that will ensure the patient is comfortable at certain level. According to Kolcaba "comfort is the desirable state that nurses would want for their patients" (Merkel, 2007).

Method

This part presents and describes the research design, participants of the study, data gathering procedures in conducting the study and the statistical treatment used to interpret the data gathered.

Design

The descriptive type of research was utilized in the study which determined the extent of palliative care rendered by clinical nurses in terms of physical, psychological, social, spiritual, cultural, and ethical aspects. Descriptive research is defined as a process of gathering information about present existing condition, which aims to describe the nature of the situation, as it exists at the time of the study and to explore the cause of particular phenomena. Descriptive method is the appropriate and accurate method in gathering data. It exists when two different measures of the same people, events, or things vary together. It is collected through questionnaire and interview.

Participants

The target population of the study was purposively chosen one hundred (100) from palliative patient's ages thirty (30) years old and above admitted in different hospitals in

Batangas province, namely Batangas Regional Hospital, Jesus of Nazareth Hospital, Golden Gate General Hospital, Bauan Doctors Medical Center, and Batangas Provincial Hospital as well as significant others of palliative patients. These are adult patients who had acute, serious life threatening (stroke, trauma, major Myocardial Infarction and Cancer) and progressive chronic illnesses (End Stage Renal Disease, Diabetes Mellitus, Congestive Heart Failure, Chronic Obstructive Pulmonary Disease, and Arthritis). They are conscious, coherent, without any contraptions that hinder communication such as on-going oxygen inhalation, ventilators, naso-gastric tube, and tracheostomy tube.

Instruments

The first draft of questionnaire was submitted for validation to the research director and then the second draft was made soon after it was approved and validated. A pilot test was conducted to thirty (30) respondents who were excluded in the actual study to determine the adequacy, validity and reliability of the questionnaire.

The instrument used was a close-ended questionnaire. The indicators of the questionnaire were taken from the principles and guidelines of palliative care. Experts were consulted to determine its practicality and reliability. The draft was revised prior to pre- testing. The result of the pilot- test was used to revise the final draft of the questionnaire.

The main instrument used in this study was a self-made survey questionnaire. This measured the variables under this study which consisted of two parts. The first part consisted of respondent’s profile such as gender, age, highest educational background, monthly family income, medical diagnosis, and length of disease, current medical and nursing management. The second part investigated the extent of palliative care rendered by the clinical nurses as perceived by the patient and relatives/significant others in terms of physical, psychological, social, spiritual, cultural, and ethical aspects. Additional guide questions were formulated to support the data to be gathered from the questionnaire.

Procedures

After the accomplishment of the final draft of questionnaire, a letter addressed to the Medical Director of different hospitals signed by the Research Director was presented asking permission to conduct the study utilizing their patients and their relatives / significant others. The purposes of the study were explained in detail. Pilot study using thirty (30) patients as well as relatives / significant others was done to validate the tool. After validation and revision, questionnaires were distributed. The data gathered was collected, tallied and tabulated.

Data Analysis

To facilitate the analysis of the study and to arrive at specific conclusions, the descriptive statistics were used.

Frequency distribution was utilized for describing the profile. Weighted mean measured the extent of palliative care rendered by clinical nurses.

The following scales were used to interpret and analyse the results. For the extent of utilization:

Scale	Description	Range
5	Very Great Extent	4.50-5.00
4	Great Extent	3.50-4.49
3	Moderate Extent	2.50-3.49
2	Less Extent	1.50-2.49
1	Not at All	1.00-1.49

Results and Discussion

This part presents the data gathered with their analysis and interpretation consistent with the problems raised and hypothesis being tested.

Table 1.1 discusses the profile of the patient respondents in terms of gender, age, highest educational attainment, family monthly income, and currents medical or nursing management.

It shows that male is greater than female with a percentage of fifty nine (59). During the conduct of this study, they were the ones suffering from rheumatic disorders, congestive heart failure, chronic renal failure, cancer, and obstructive pulmonary disease. According to most female respondents, they experienced increased weight during their menopausal period which is a factor to develop Diabetes Mellitus (DM) that manifests hypertension which may result to cerebrovascular disease if not attended at early stage. American Diabetes Association (2004), cited by Smeltzer, et al. (2010), assumed that long term effects of hyperglycemia contribute to macrovascular complications such as

Table 1.1
Percentage Distribution of the Patients' Profile

Profile Variable	Frequency	Percentage (%)
Gender		
Female	41	41.0
Male	59	59.0
Age		
30 – 35 years old	6	6.0
36 – 40 ears old	3	3.0
40 – 45 years old	8	8.0
46 – 50 years old	13	13.0
51 years old	70	70.0
Highest Educational attainment		
Elementary graduate	62	62.0
Secondary graduate	21	21.0
Vocational graduate	6	6.0
College graduate	10	10.0

Post collegiate study	1	1.0
Family Monthly		
Php 5,000 and below	69	69.0
Php 5,001 to 10,000	12	12.0
Php 10,001 to 20,000	9	9.0
Php 20,001 to 30,000	4	4.0
Php 30,001 to 40,000	3	3.0
Above 40,000	3	3.0
Medical Diagnosis		
Rheumatic Disease	8	8.0
Congested Heart Disease	6	6.0
Cerebro Vascular Disease	33	33.0
Chronic Obstructive	6	6.0
Pulmonary Dis	27	27.0
Diabetis Mellitus	10	10.0
Chronic Renal Disease	10	10.0
Cancer		
Length of time had been diagnosed		
Less then I month	10	10.0
1-6 months	13	13.0
7-12 months	4	4.0
1-5 years	44	44.0
6-10 years	19	19.0
11-15 years	5	5.0
16 years & above	5	5.0
Nursing Management ***Multiple Response**		
IVF	78	78.00
IV INJ	67	67.00
ORAL MED	70	70.00
OXYGEN INHALATION	23	23.00
BLOOD TRANSFUSION	10	10.00
DIET THERAPHY	83	83.00
WND DRESS	7	7.00
DIALYSIS	8	8.00
ENEMA	1	1.00
PYSICAL THERAPY	1	1.00
NEBULIZATION	6	6.00
TRACTION	1	1.00

CYSTOCLYSIS	1	1.00

coronary artery disease, cerebrovascular disease, and peripheral vascular disease.

High percentage of the types of chronic disease in male accounts for their lifestyle of taking alcohol, smoking cigarette, and encountering pollutants outside home. Specifically, respiratory disease, cancer, so with stroke and DM account for 300,000 deaths every year in the Philippines (DOH 2012). In the USA, according to Arias, Anderson, Hsiang-Ching, et al. (2003) cited by Smeltzer, et al. (2010) the ratio of COPD is one (1) male to four (4) female.

As to the age of patients, fifty-one (51) years old got seventy (70) percent followed by forty-six to fifty (46-50) years old which is thirteen (13) percent. Chronic and life-threatening illnesses commonly occur on this stage because of different factors like previous illnesses, genetic factors, or injury. It may also be a consequence of conditions or unhealthy behaviors that began during childhood and young adulthood. In this study, respondents claimed that they have started smoking cigarettes and taking alcohol during their teen-age life which are risk factors for chronic respiratory diseases, DM, which may also end up to chronic renal failure and heart failure.

In terms of highest educational attainment, elementary graduate is the highest, sixty-two (62) percent, which also relates to the highest percentage in family income of five thousand pesos (P 5,000) and below which is sixty-nine (69) percent. Respondents claimed that they have no permanent job before, they engaged in farming and construction works, and at present are dependents of their children and relatives or siblings working locally or abroad.

Respondents were proportionately taken from both public and private hospitals that show relationship of economic status to educational attainment or vice versa. Universally, chronic conditions occur in people of every age group, socio-economic level, and culture. As posited by Reyala (2007), socioeconomic status is an important predicator of health; Maglaya (2009), included access to basic health services, and inability to make decisions on health matters in the list of factors that lead to increased morbidity and mortality rate in the Philippines. Access to quality health care facilities and services is a problem to most number of patients specifically in developing countries. Wilson (2009), concluded in his study that socioeconomic level is associated to poor access to specialist palliative care.

Among chosen medical diagnosis, cerebrovascular disease (CVD) of thirty three (33) percent topped, followed by DM of twenty seven (27) percent, and the least are the congestive heart disease of both six (6) percent. During the conduct of this study CVD patients were high in number as this is the result of many problems like obstruction of blood vessels, increased metabolites in the blood circulation, increased blood sugar level, and insufficient blood supply to the brain related to heart disease. All of which, manifest abnormal increase in blood pressure. In the Philippines, CVD is the second leading cause of mortality (Philippine Health 2009) and the third World Wide (WHO Health Report 2010).

The least in rank is COPD, that during data collection those patients suffering from the critical stage of COPD were in the intensive care unit (ICU) connected to mechanical ventilator as the primary management to their respiratory distress. Chronic lower respiratory diseases which include COPD are the eighth leading cause of mortality in the Philippines (Philippine Health 2009) and the fifth worldwide (Sindico 2012).

In terms of the length of time the patient had been diagnosed with the disease, range of one to five (1-5) years is the highest. These were the patients who suffered from rheumatic disease, diabetes mellitus who are maintaining their blood glucose to normal level and preventing complications, and cerebrovascular disease who are manifesting chronic hypertension. Patients who were diagnosed seven to twelve (7-12) month's ago were the cancer patients representing four (4) percent as the very least. Next are the ones who were diagnosed eleven to fifteen (11-15) years and above sixteen (16) years already. Both groups have five (5) percent each. From the data gathered they were the diabetic and hypertensive patient maintaining their quality of lives.

Current medical and nursing management are the therapeutic interventions that patients are receiving during the data gathering. Most of them received three to four interventions. Diet therapy is the highest which is eighty-three (83) percent. Diet therapy or nutritional support is based on the underlying cause of disease which is served in regular, soft, blenderized, and liquid form. Like in diabetic patient, the important objectives in dietary and nutritional management are control of total calorie intake or maintain reasonable weight, control of blood glucose level, and normalization of lipids and blood pressure level to prevent heart disease (Smeltzer, 2010). This is a plan and prepared by a registered dietician and to be served by the nurses.

For COPD patients, high caloric diet and supplementation are needed to compensate for weight loss and loss of fat mass as patient tolerates.

For patient with deterioration of kidney function dietary intervention is very necessary. Careful regulation of protein intake and fluid intake to balance losses is observed, and sodium intake to balance sodium losses and some restrictions of potassium. Simultaneously adequate caloric intake and vitamin supplement must be ensured. Smeltzer, et al (2010), explained that protein is restricted because urea, uric acid, and organic acids – the breakdown products of dietary and tissue proteins accumulate rapidly in the blood where there is impaired renal clearance. The allowed protein must be of high biologic value proteins that supply the essential amino acids necessary for growth and repair of cells. For fluid intake the allowable amount is 500 to 600 mL more than the amount of previous day's urine. For the prevention of increased potassium in the blood (hyperkalcemia), careful monitoring of diet, medications, and fluids for potassium content must be done. This is also through dialysis if patient is undergoing dialysis.

Similarly, for patients manifesting signs and symptoms of heart failure such as edema, hypertension, pulmonary congestions, nutritional or dietary therapy is essential. A low-sodium (2 to 3 g/day) diet and avoidance of excessive amount of fluid are usually recommended. Dietary restriction of sodium reduces fluid retention, and symptoms of peripheral and pulmonary congestion. The purpose of sodium restriction is to decrease the amount of circulating blood volume, which would decrease the need for the heart to pump that volume. Any change in diet needs to be made with consideration of good nutrition as well as patient's likes, dislikes, and cultural food patterns (Smeltzer, et al. 2010).

Contrary to dietary support for cancer patients, no restrictions advised to caloric and protein intake. Impaired nutritional status may contribute to disease progression, decreased survival, immune incompetence, and increased incidence of inflectional and decreased capacity to continue antineoplastic therapy (Smeltzer, et al. 2010). Likewise, for patients with rheumatic disorders, food selection should include the daily requirements from the basic food groups, with emphasis on foods high in vitamins, protein, and iron for repair of tissues.

Next in rank is the administration of intravenous fluids. This comes in three classifications, the hypertonic, isotonic, and hypotonic solutions. These consist of dextrose solutions, electrolytes, medications, or blood products. These are administered based on the prescriber's assessment on current laboratory results and the patient's clinical needs. Solutions are ordered to be either continuous or intermittent, depending on the fluid and simultaneously intravenous infections of antibiotic, hormone, and vitamins are administered through intravenous solutions for faster action with fewer traumas to skin and muscle. Meanwhile, oral medications are given as indicated, though patient also receives intravenous solutions.

Oxygen inhalation is very essential support to patients with difficulty in breathing, in pain and imbalance blood gas. This therapy prevents oxygen deficiency which may result to death of cells, tissue, and organ. In this study patient's diagnosis with COPD, heart failure, and cancer received the therapy.

Blood transfusion is the replacement of lost blood components such as red and white blood cells, platelets, or blood proteins because of hemorrhage or disease, to restore the blood's ability to transport oxygen and carbon dioxide, to clot, to fight infection, and to keep extracellular fluid within the intravascular compartment. Blood transfusion is introduced into the venous circulation (Kozier and Erb, 2008). In this study patients with chronic renal disease and cancer were the ones who received the management. They experienced low production of erythropoietin by the kidney which is responsible for the production of red blood cells and for cancer patients, chemotherapeutic agents cause depression of bone marrow which resulting to decreased production of red blood cells (Smeltzer et al. 2010).

Nebulizer is one of the nursing management to dispense a moisturizing agent or medication, such as bronchodilator or mucolytic agent, into microscopic particles and delivers it to the lungs as the patient inhales (Smeltzer et al 2010). Patients with COPD received this treatment.

Dialysis is a procedure done to patients with chronic renal failure to remove fluid and uremic waste products from the body when the kidneys are unable to do (Smeltzer et al. 2010).

Daily dressing of wound was done to those diabetic patients who have limb amputation.

Other management like cystoclysis, enema, and application of traction were done to single number of patient each. Cystoclysis is the administration of large amount of distilled water into the bladder via catheter inserted through the urethra. Its purpose is to cleanse the bladder from bleeding. Likewise, enema is to evacuate impacted feces through administration of solution to soften stools; and skin traction for patient with rheumatic disorder to reduce muscle spasm, to immobilize the extremity, and to relieve pain.

Table 1.2
Percentage Distribution of the Significant Others' Profile

Profile Variable	Frequency	Percentage (%)
Gender		
Female	81	81.00
Male	19	19.00

Age		
30 – 35 years old	21	21.00
36 – 40 years old	14	14.00
40 – 45 years old	16	16.00
46 – 50 years old	25	25.00
51 years old	24	24.00
Highest Educational attainment		
Elementary graduate	28	28.00
Secondary graduate	45	45.00
Vocational graduate	6	6.00
College graduate	18	18.00
Post collegiate study	3	3.00
Family Monthly		
Php 5,000 and below	68	68.00
Php 5,001 to 10,000	21	21.00
Php 10,001 to 20,000	4	4.00
Php 20,001 to 30,000	3	3.00
Php 30,001 to 40,000	4	4.00
Above 40,000	0	0.00

Table 1.2 shows the percentage distribution of the significant other's profile. The female significant others out-numbered male in taking care of their sick relatives. Female is eighty one (81) percent who possess natural caring characteristics. Women provide the majority of informal care to spouses, parents, parent – in – law, friends and neighbors. As previously mentioned females life expectancy is longer than male and female ages 65 and over is 2,471,644 compared to male which is 1,8766,805 (Philippines Demographic Profile, 2012).

Most men representing the nineteen (19) percent were only substitute or reliever to female care giver doing something at home and will come back to stay with the patient.

Age of significant others ranging forty six to fifty (46-50) years old got twenty five (25) percent, followed by fifty one years old and above. They are the wives and sisters of patients capable of staying day and night in the hospitals taking care of their sick love ones. The least is age range of thirty six to forty (36-40) with fourteen (14) percent. Included here were daughters of the patients

In terms of highest educational attainment forty five (45) percent finished secondary, followed by elementary graduate with twenty eight (28) percent, college graduate of eighteen (18) percent, vocational graduate of six (6) percent and the least is post collegiate study of three (3) percent. These findings could be related to their highest monthly income that the Php 5,000 and below get sixty eight (68) percent followed by Php 5,001 to Php 10,000. Most male respondents are engaged in farming and vegetable raising and hog contact growing. Some are in construction works. For females, they are helping their husband as plain house wife and sometimes receiving certain amount from relatives, sibling, sons and daughters already with family of their own.

Least is those earning Php 20,000 to Php 30,000 and Php 30,000 to Php 40,000 which align to the percentage of college graduate and with no post collegiate study.

These also show that respondents are not highly educated which may relate to poverty, and low income at the end.

Sirhak (2006) stated that poverty means low education. The difference in views regarding poverty would pose difficulties to categorize people or poor. Some view poverty as a situation of lack in resources, while to others it is rooted in the uneven distribution of resources. In this study, specifically health resources are related to having chronic and debilitating disease. Reyala (2007) posited that higher income and social status are linked to better health; low education levels are linked with poor health. Similar to Grande and Campbell (2009), concluded in their study that socioeconomic status is a predictor of access to palliative care services.

Table 2.1 shows the weighted mean distribution of the palliative care rendered by clinical nurses in terms of physical aspect as perceived by patients and relatives with a composite mean of 3.74 and 3.75 respectively; both verbally interpreted as great extent.

Nurses serves proper diet, ranks first (x=4.29) and (x=4.38) as perceived by the patients and relatives respectively, both verbally interpreted as great extent. Respondents believe that part of nurse's responsibility is to know and

Table 2.1
Palliative Care Rendered by Clinical Nurses in terms of Physical Aspect of Care
N=200

	Patients			**Significant Others**		
The nurse:	**Mean**	**VI**	**R**	**Mean**	**VI**	**R**
1. assesses patient's understanding of the disease and its consequences.	3.82	GE	4.5	3.89	GE	4
2. performs regular and ongoing assessment of pain experienced by the patient.	3.91	GE	3	3.98	GE	3
3. observes non-pain symptoms including but not limited to shortness of breath, nausea fatigue, anorexia, insomnia, and constipation	3.82	GE	4.5	3.73	GE	5
4. provides basic comfort and supportive care regularly and as needed such as bed bath, hot and cold therapy, passive exercises and turning to sides.	2.80	ME	8	2.78	ME	8
5. recognizes and addresses the	3.49	ME	7	3.47	ME	7

barriers to effective pain management such as fear of side effects, addiction, respiratory depression, and hastening of death in association with opiod.						
6. administers pain and symptom management safely and timely that is acceptable to the patient	3.97	GE	2	4.02	GE	2
7. serves proper diet	4.29	GE	1	4.38	GE	1
8. responds to symptoms distress promptly and tracked through documentation in the medical record	3.80	GE	6	3.71	GE	6
Composite Mean	**3.74**	**GE**		**3.75**	**GE**	

Legend: 4.50 – 5.00 = Very Great Extent; 3.50 – 4.49 = Great Extent; 2.50 – 3.49 = Moderate Extent; 1.50 – 2.49 = Least Extent; 1.00 – 1.49= Not at all

supervise serving proper diet to the patients prepared by a registered dietician. They know that nutritional support or diet therapy is essential to the disease management.

Examples of these are diabetic diet, low salt, low fat diet, low purine diet, high caloric diet, and high protein diet prepared in a regular, soft, and pureed or blenderized diet. Indrani (2003), discussed diet therapy deals with modifications necessary in the treatment of different diseases. This is necessary as the metabolism of the individual changes in different diseases with respect to one or more nutrients. Dudeck (2010) added that therapeutic diet differ from a regular diet in the amount of one or more nutrients or food components for the purpose of preventing or treating disease or illness.

Administering pain and symptoms management safely and timely that is acceptable to the patient ranks second (x=3.97) and (x=4.02) as perceived by the patients and relatives respectively. Respondents claimed that nurses answers immediately to their complaints especially for pain management. Pain is considered as the fifth vital sign that its significant that its significance must be emphasized to increase the awareness among health care professionals. Pain is assessed in all patients and that patients have the right to appropriate assessment. It suggests that assessment of pain should be as automatic as taking patient's blood pressure and pulse (JACAHO 2005, cited by Smeltzer et al. 2010). It must be remembered that pain assessment is a multidisciplinary responsibility and must go hand in hand with thorough medical examination and investigation into possible causes of pain (Kinghorn and Gains, 2007). Pain assessment does not stop with the identification of pain, but needs to be ongoing throughout any treatment. Failure to do proper assessment may result to under or over treatment (Kinghorn and Gains, 2007). Addiction is characterized by craving for the drug and an overwhelming preoccupation with obtaining it (McCaffery & Ferrell 1997 cited by Kinghorn and Gains 2007). It is perhaps the most common fear and misconception, and yet is almost never an issue in clinical practice. Constipation, nausea, and drowsiness are side effects of opiod that should be rationalized to patients (Kinghorn and Gains 2007).

Third in rank is performing regular and ongoing assessment of pain experienced by the patient (x=3.91) and (x=3.98) or perceived by the patient and relatives respectively and both interpreted in great extent. As quoted by JACAHO (2005), pain assessment should be automatically included in assessment of vital signs. In the meaning process, assessment must be done first prior to any interventions, but the respondents noticed that when they call for pain management, nurses respond and will do thorough assessment related to pain.

Ranks fourth is the assessment of patient's understanding of the disease and its consequences (x=3.82) and (x=3.89) as perceived by patients and relatives respectively and verbally interpreted as both great extent. Respondents stated that, asking about their disease and possible outcomes is being done when nurses measure their blood pressure and when giving medicines. These are not asked upon admission to the ward or unit. According to Patient Bill of Rights (1992), the patient has the right to and is encouraged to obtain from physicians and other direct caregivers relevant, current, and understandable information concerning diagnosis, treatment, and prognosis. The practice of most nurses where the study conducted; they are not the one giving firsthand information if in case the patient didn't know yet the details of her disease. The admitting and the attending physician are in the position for details. Physical assessment is the one being done first by the nurse that should include level of patient's understanding.

Observing non-pain symptoms including but not limited to shortness of breath, nausea, fatigue, anorexia, insomnia, and constipation ranks fifth (x=3.82) and (x=3.73) as perceived by patients and relatives respectively both interpreted as great extent. Respondents declared that it is during nurse's endorsement rounds that they are asked about other symptoms or present complaint not really observing regularly. When symptoms felt, the relatives or watchers will communicate to the nurse on duty and that will be the time to come as response to care. Other signs and symptoms may appear as complication develops and patient manifests his/her present health condition.

Responding promptly to symptoms distress and later tracked through documentation in the medical record ranks sixth (x=3.80) and (x=3.71) as perceived by patients and relatives respectively both verbally interpreted as great extent. As related to the fifth rank, nurses respond immediately but this is after knowing from the relatives or watcher. They document as basics for referral to physician on duty.

According to the respondents the nurses rarely ask about fear of side effects and addiction to pain reliever; they ask about known allergies and they are not explaining that the drug may lead to addiction, and respiratory depression. The doctors are the one telling them. This is an evidence that this item ranks seventh, (x=2.80) and (x=2.78) by patients and relatives respectively, verbally interpreted as moderate extent. Mulholland (2007), added to basic patient's right are the right information and right documentation. Contrary, patients claimed, not all nurses are asking about fear of drugs side effects because they are the one in fear of barriers to effective management.

The last in rank is the provision of basic comfort and supportive measures like bed bath, hot and cold application, passive exercises, and turning to sides, (x=2.80) and (x=2.78) both perceived by patients and relatives as moderate extent. Everybody knows that the primary role of the nurse is to provide physical care to his/her patients. Respondents pointed out very rare the nurses are doing this. Respondents claimed that nurses only give medicines; delegate this kind of work to their nursing aide or the relatives themselves are the one providing the physical care.

Table 2.2 displays the palliative care rendered by clinical nurses in terms of psysiological aspect of care with a composite mean of 3.28 and 3.19 as perceived by the patients and relatives respectively, both verbally interpreted as moderate extent.

First in rank, nurse uses knowledge of verbal and non-verbal communication skills to spend time to establish rapport to enable trust to develop. As perceived by the patient (x=3.52), it is at great extent and by significant others (x=3.48), it is at moderate extent. They differ in perceptions because the patient can feel the presence of the nurse whenever they are asked about pain observed through facial grimace and through therapeutic touch, while for significant others they claimed that not all nurses are responding to patient's reactions whether verbal or non-verbal. They insisted that most nurses come to answer patient's need when called by watcher or relatives. Non-verbal communication often tells what is actually said because nonverbal behaviour is

Table 2.2
Palliative Care Rendered by Clinical Nurses in terms of Physiological Aspect of Care
N=200

	Patients			**Significant Others**		
The nurse:	**Mean**	**VI**	**R**	**Mean**	**VI**	**R**
1. enables patient and family / carer to express their feelings and worries related to illness, listening, and showing empathy.	3.49	ME	2	3.41	ME	2
2. assess psychological difficulties like social isolation disruption of job and daily activities, sexual dysfunction, and associated relationship.	3.02	ME	7	2.89	ME	7
3. refers patient to health care professionals like psychologist, counselor, helping groups, and social workers.	2.99	ME	8	2.76	ME	8
4. assess patient's family / carer care giving capacities, needs, and coping strategies.	3.33	ME	4	3.30	ME	4
5. provides comfort through touch as/when it is appropriate, like holding patient's hand or putting a hand on him/her.	3.45	ME	3	3.37	ME	3

6. uses knowledge of verbal and non-verbal communication skills to spend time to establish a rapport to enable trust to develop.	3.52	GE	1	3.48	ME	1
7. helps patient make sense of his/her illness and prognosis by offering hope, facilitating reflection of life and values, fulfilling his/her wishes and attempting to meet spiritual needs.	3.19	ME	6	3.08	ME	6
8. supports patient and family/carer to explore the issues arising from the transition from curative care to palliative care.	3.28	ME	5	3.23	ME	5
Composite Mean	**3.28**	**ME**		**3.19**	**ME**	

Legend: 4.50 – 5.00 = Very Great Extent; 3.50 – 4.49 = Great Extent; 2.50 – 3.49 = Moderate Extent; 1.50 – 2.49 = Least Extent; 1.00 – 1.49= Not at all

controlled less consciously than verbal behavior (Kozier 2008). So, observation and interpretation of non-verbal behavior is a skill for nurses to develop. Essentially, patients benefit from the result of nurse's assessment and consequently trust and rapport will be developed between them if the nurse will spend even a little time with the patient.

Second in rank, nurse enables patient and family carer to express their feelings and worries related to illness, listening and showing empathy, (x=3.49) and (x=3.41) as perceived by patients and significant others respectively, both with verbal interpretation of moderate extent. Twenty (20) percent of the respondents both patients and significant others commented that nurses are not enabling them to express what they feel, no time to listen nor showing empathy; to others, there are some who listens but simply listening not absorbing the content and the feeling the patients are conveying. According to Egan (1998) cited by Kozier (2008), empathy involves understanding correctly another person's emotional state and point of view and also as an emotional response experienced by the helper. What could be the reasons? Both respondents disagreed that nurses have no time to spare for emphatic listening and responding.

Provision of comfort through touch and holding patient's hand ranks third (x=3.45) and (x=3.37) as perceived by patients and significant others respectively. Similar to the previous items, it ranks high but performs by nurses at moderate extent only. There were patients who mistakably interpret measuring blood pressure and counting pulse rate as touch, but contrarily, there were also claimed that there are nurses touched them appropriately. They felt relief and loved by those nurses. Using touch is therapeutic communication techniques (Kozier, 2008) that reinforce caring feelings.

Ranks fifth is supporting the patient and family/carer to explore issues arising from the transitions from curative care to palliative care, (x=3.28) and (x=3.23) as perceived by patients an significant others respectively, both verbally interpreted as moderate extent. Most respondents stated that the doctors are the one explaining to them the transition of care from curative to palliative and issues that may arise during the phases of management. Giving information is also one of the techniques of therapeutic communication. When information is not known, the nurse states this (Kozier 2008). Therefore, in this study clinical nurses are selective to what information to reveal to palliative patients. However, it is a responsibility of the nurse to give right information to his/her patient.

Helping patients make sense of his/her illness and prognosis by offering hope, facilitating reflection of life and values, fulfilling wishes and attempting to meet spiritual needs rank sixth (x=3.19) and (x=3.08) as perceived by patients and significant others respectively. Both verbally interpreted as moderate extent. Similar to the previous item, patients stated that only few nurses specifically the charged nurse or the head nurse discusses the expected outcome of treatment in relation to the disease. Respondents praise nurses because of offering hope through mentioning God's name, but to facilitate reflection of life and values seems no time to stay long beside them. According to Obrien (2011), spiritual care was generally not considered a dimension of nursing therapeutic, but because of holistic nursing, patient's spiritual needs became recognized and legitimate activities within the domain of nursing.

The seventh rank which is assessing psychological difficulties like social isolation, disruption of job and daily activities, sexual dysfunction, and associated relationship (x=3.02) and (x=2.89) as perceived by patients and significant others respectively are verbally interpreted as moderate extent. Most of the respondent commented that very few nurses are doing this, or may be concern only to physical aspects, but the nurse trainees did sometimes. For them, it's a doctor concern.

Lastly, referring patient to health care professionals like psychologists, counselors, helping groups, and social workers (x=2.99) and (x=2.76 as perceived by patients and significant others respectively are both in moderate extent. According to respondents, head nurses are referring them to medical social services for charity medicines only and for reduction of payment of hospital bill to certain amount.

Kozier (2010), emphasized the major functions of the nurse's role in the self-help group of which three of those are applicable in Philippine setting such as, to inform clients and support persons about existing self-help group available to them, participate as a member of a self-help group when this is appropriate, nurse as a resource person, that is, of being "on tap, but not on top"; unaware of any existing helping groups in the locale on this study.

Table 2.3 manifests the palliative care rendered by clinical nurses in terms of social aspect of care with a composite mean of 2.98 and 2.95 as

Table 2.3
Palliative Care Rendered by Clinical Nurses in terms of Social Aspects of Care

	Patients			**Significant Others**		
The nurse:	**Mean**	**VI**	**R**	**Mean**	**VI**	**R**
1. confidently facilitates and	3.06	ME	2	3.08	ME	2

manages interactions with patient, family, and other members of the health care team.						
2. appraises the patient's social needs and desires for social support.	2.84	ME	7	2.77	ME	6.5
3. assists the patient and family to identify available support systems to include in the plan of care.	2.87	ME	6	2.77	ME	6.5
4. provides an atmosphere of acceptance that patient and family believe that they are cared for and loved.	3.34	ME	15	3.41	ME	1
5. facilitates patient's and family's / career's coping behavior through identifying the nature of social support.	2.91	ME		2.84	ME	5
6. assists the patient and family to identify positive strategies to deal with limitations and manage needed lifestyle or role changes.	2.99	ME	4	2.89	ME	4
7. helps minimize adverse impact of care giving on the family and promotes caregiver's and family's goals, and well-being.	3.01	ME	83	3.05	ME	3
8. refers patient to facilities for rehabilitation, counseling, and equipments.	2.80	ME		2.75	ME	8
Composite Mean	**2.98**	**ME**		**2.95**	**ME**	

Legend: 4.50 – 5.00 = Very Great Extent; 3.50 – 4.49 = Great Extent; 2.50 – 3.49 = Moderate Extent; 1.50 – 2.49 = Least Extent; 1.00 – 1.49= Not at all

perceived by the patients and significant others respectively and both interpreted as moderate extent.

The nurse provides an atmosphere of acceptance that patient and family believe that they are cared for and loved (x=3.34) and (x=3.41) as perceived by patients and significant others respectively. Respondents felt the love and care of nurses at moderate extent. It is the patient's right for considerate and respectful care (Burkhardt and Nathaniel, 2002), so nurses must provide care holistically regardless of nationality, religion, gender, status in life, and disease condition. By then, they are loved and cared for. Respondents pointed out that nurse trainees are closer to them showing empathy compared to regular staff nurses.

Facilitating and managing interactions with patient, family, and other members of the health care team is second in rank (x=3.06) and (x=3.08) as perceived by the patients and significant others respectively. Both are interpreted as moderate extent. Respondents see nurses joining their doctors during rounds and facilitate interactions among members of the team, and between patient and doctor. Nurses briefly discuss patient's current condition during the rounds, which facilitates understanding of the care. Being a facilitator is a role of a nurse to perform (Allender, 2010).

Helping minimize adverse impact of care giving on the family and promoting care giver's and family's goals and wellbeing ranks third (x=3.01) and (x=3.05) as perceived by patients and significant others respectively. Both interpreted as moderate extent. Both respondents, patients and significant others believe, not all nurses are helping them on this matter. There were some who really spent few minutes to talk about adverse impact of care giving. Nurses assess family functioning to determine how the particular family will cope with the impact of the health condition and care. According to them, there are different attitudes and approaches among family members. Some support the idea of palliative care while others want to try every medical intervention to keep loved one alive for as long as possible. The patients themselves are afraid to die despite the fact that management is no longer curative. Contrarily, are nurse's reports that patient needing care is often more resolved or emotionally prepared than his family.

Ranks fourth is assisting the patient and family to identify positive strategies to deal with limitations and manage needed lifestyle on role changes (x=2.99) and (x=2.89) as perceived by patients and significant others respectively, both interpreted as moderate extent. Similar to the previous item, respondents expressed that nurses are not one assisting or teaching them how to deal with limitations. It's a doctor's concern, but for lifestyles and role changes nurses are also suggesting having an open communication among members of the family.

Ranks fifth, the nurse facilitates through identifying the nature of social support (x=2.91) and (x=2.84) as perceived by patients and significant others respectively, both interpreted as moderate extent. Respondents acknowledge the health benefits given by the local government of Batangas City but insufficient for patient's needs especially for medicines and diagnostic procedure. For them, nurses rarely teach coping behavior. They just enumerate what to do but the way or how to do the actions is lacking. Nurses only ask if there are support groups or family members to support specifically for the continuity of medications. They are not making formal referral when it comes to social and financial support specifically but for medical care the doctors are the one making referrals to a secondary or primary health care facilities.

Ranks sixth, the nurse assists the patient and family to identify available support systems to include in the plan of care (x=2.87) and (x=2.77) as perceived by the patients and significant others respectively, both interpreted as moderate extent. As mentioned in the previous item (rank fifth) according to the respondents nurses rarely help on this matter. It's enough for them to ask if support will be available specifically after discharge from the hospital.

It is important to assist patient and family to know the resources of care such as financial, facilities and the health programs available in the community, including the health workers whom they can go for assistance to care.

Rank seventh, the nurse appraises the patients social needs and desires for social support (x=2.84) and (x=2.77) as perceived by the patients and significant others, respectively, both interpreted as moderate extent. Repeatedly commented by the respondents that not all nurses ask about their social needs and who will give the social support. According to them, their attending physician assesses prior to discharge the patient's new roles and capacities in the family, and interested to know the significant others who could help or continuously takes care of the patient. It is essential to the plan of care, the nature of social support and its influence on coping should be appraised. Ben-Ari (2004) cited by Smeltzer, et. al, 2010), posited that social support has been demonstrated to be an effective moderator of life stress; provide people with different type of emotional information that patients are cared for and loved; leads people to believed that they are esteemed and valued; leads people to feel that they belong to a network of communication and mutual obligation. Social support also facilitates a person's coping behavior.

Eighth in rank, nurse refers patient to facilities for rehabilitation, counseling, and equipment's (x=2.80) and (x=2.75) as perceived by patients and respectively, both interpreted as moderate extent. It is expected that the nurses has a significant role and responsibility in identifying physical, psychological, social, and other aspects of patient's needs since admission up to going home. This will be the main reason for making referrals for rehabilitation, counseling, and continuation of care in general. Unfortunately, primary and secondary health care facilities lack in resources, so upon knowing the situation, no referrals made for rehabilitation purposes. Attending physician orders the patient when to come back for follow up check-up.

Table 2.4 presents palliative care rendered by clinical nurses in terms of spiritual aspects of care. It further shows that the item, "allows the patient to use or display religious symbol", ranked first with a weighted mean of 3.47 and verbally interpreted as "moderate extent" in respondents patient. Similarly in significant others it also ranked first.

Table 2.4
Palliative Care Rendered by Clinical Nurses in terms of Spiritual Aspects of Care

	Patients			Significant Others		
The nurse:	Mean	VI	R	Mean	VI	R
1. identifies patient's religious and spiritual background, preferences, beliefs, rituals and practices.	3.26	ME	3	3.20	ME	3
2. facilitates the process of finding the meaning and purpose in life.	3.15	ME	4	3.14	ME	4
3. supports faith needs and safely provides time for ritual	3.08	ME	6	3.02	ME	5

and devotional practices.						
4. facilitates contact with spiritual / religious communities, groups, or individuals as requested.	2.71	ME	8	2.58	ME	8
5. allows the patient to use or display religious symbol.	3.47	ME	1	3.41	ME	1
6. establishes trust and unconditional acceptance to patient and family.	3.34	ME	2	3.33	ME	2
7. assists in forgiving and life completion task.	2.79	ME	7	2.65	ME	7
8. be fully present and opens to spiritual issues as they arise.	3.12	ME	5	2.98	ME	6
Composite Mean	**3.12**	**ME**		**3.04**	**ME**	

Legend: 4.50 – 5.00 = Very Great Extent; 3.50 – 4.49 = Great Extent; 2.50 – 3.49 = Moderate Extent; 1.50 – 2.49 = Least Extent; 1.00 – 1.49= Not at all

The item, "establishes trust and unconditional acceptance to patient and family", ranked second with the weighted mean of 3.34 and 3.33 respectively and verbally interpreted as "moderate extent".

Third in the rank, for both patient and significant others was "identifies patient's religious and spiritual background, preferences, beliefs, rituals and practices" with a weighted mean of 3.36 and 3.20 respectively and verbally interpreted as moderate extent. Next in the list is the item "facilitates the process of finding the meaning and purpose in life" ranked fourth with the weighted mean of 3.15 and 3.14 respectively for patients and significant others.

The item, "be fully present and opens to spiritual issues as they arise", ranked fifth with the weighted mean of 3.12 and 2.98 for the respondents patients and significant others respectively, both verbally interpreted as moderate extent.

Meanwhile supporting faith needs and safely providing time for ritual and devotional practices rank sixth with the weighted mean of 3.08 and verbally interpreted as moderate extent in respondents' patient. Among respondents significant others it ranked fifth with a weighted mean of 3.02 also verbally interpreted as moderate extent. Additionally, the items "assist in forgiving and life completion task" ranked seventh for both the respondents.

The item "facilitates contact with spiritual/religious communities, groups, or individuals as requested", ranked eight both patients and significant others.

The overall weighted mean of the items in terms of spiritual aspect of care for respondents' patient is 3.12, while among significant others is 3.04 with the verbal interpretation of moderate extent.

According to Obrien (2011), in the past, spiritual care was generally not considered a dimension of nursing therapeutics. However with the notion of holistic nursing, assessment of ill person's spiritual needs became recognized as legitimate activities within the domain of nursing. The Joint Commission for Accreditation of Health Care Organization (JCAHO) has organized the importance of spiritual and religious beliefs and traditions for persons who are ill or disabled. It created standards of practice in the year 2003. It suggested that assessment of patient's spiritual needs should be carried out not only to determine religious denomination, but also identify spiritual and religious beliefs and practices especially related to coping with illness or disability.

Nursing authors continue to discuss the importance of assessing patient's spiritual needs, as well as the value of developing spiritual assessment tools. Similarly, for families of those who are ill (O'Brien, 2011). Moreover, the present study assesses if the patient's and family's needs are being provided in a certain extent that focused not only in spiritual aspect but also other aspects that may consider integral to nursing practice.

After assessment, nurses identify the needs and plan for an attainable and realistic interventions. O'Brien (2011), conceptualized "spirituality" dimension of spiritual being from patient's personal faith, religious practice and spiritual contentment. According to her, as contemporary nurses become more involved with diagnosis and intervention in the spiritual arena, some basic knowledge of beliefs and behaviors associated with the major religious cultures is essential. This is to allow nurses to accurately identify and address significant spiritual needs and problems exhibited or reported by their patients.

Interventions may include, giving support and providing time for rituals and devotional practices, allowing patient to use or display religious symbols, praying with the patient, reading favorite portion of the bible or scriptures, and being present and open to spiritual issues. Nurse may also refer patient to religious individual or group or to designated pastoral care giver if not personally comfortable with the practice of spiritual care. Obrien (2011) suggested that the patient might begin an ongoing discussion with the clergy or counsellor, or join a group for meditation, prayer and support. He may keep a journal to express feelings, thoughts, and memories, and can contribute to the process of self-discovery spiritual development.

Table 2.5

Palliative Care Rendered by Clinical Nurses in terms of Cultural Aspects of Care

	Patients			**Significant Others**		
The nurse:	**Mean**	**VI**	**R**	**Mean**	**VI**	**R**
1. assesses patient's background, concerns and needs.	3.14	ME	8	3.10	ME	8
2. shows desire to effectively build nurse-patient relationship considering the cultural background.	3.29	ME	4	3.28	ME	3
3. asks for clarification to what had been said, plan, and done by the patient which he/she did not understand.	3.20	ME	6	3.18	ME	6
4. recognizes and value individual differences.	3.24	ME	5	3.21	ME	5
5. respects and accommodates	3.43	ME	2	3.44	ME	2

patient's level of knowledge, dietary, and ritual practices.						
6. becomes sensitive to non-verbal cues and communication.	3.49	ME	1	3.46	ME	1
7.accepts constructive criticism, and avoid becoming defensive.	3.37	ME	3	3.26	ME	4
8. collects feedback from the patient and family.	3.18	ME	7	3.12	ME	7
Composite Mean	**3.29**	**ME**		**3.26**	**ME**	

Legend: 4.50 – 5.00 = Very Great Extent; 3.50 – 4.49 = Great Extent; 2.50 – 3.49 = Moderate Extent; 1.50 – 2.49 = Least Extent; 1.00 – 1.49= Not at all

Table 2.5 depicts the palliative care rendered by clinical nurses in terms of cultural aspects of care. As shown in the table, becoming sensitive to non verbal cues and communication is the most important items that the nurse must possess.

Secondly, respecting and accommodating patient's level of knowledge, dietary and ritual practices, thus nurses should interact with people in different cultural backgrounds. Third in the rank, according to respondents' patients was accepting constructive criticism and avoiding becoming defensive with a weighted mean of 3.37 and verbally interpreted as moderate extent. However, in respondents significant others, it rank fourth with a weighted mean of 3.26 and verbally interpreted as moderate extent. Showing desired to effectively build nurse-patient relationship considering the cultural background was rank fourth for the respondents' patients but in respondents' significant others it rank third with a weighted mean of 3.28 verbally interpreted as moderate extent.

Leininger cited that culture involves learned and transmitted knowledge about values, beliefs, and rules of behavior, and lifestyle practices that guide designated groups in their thinking and actions in patterned ways (Smeltzer, et al, 2010).

Recognizing and valuing individual differences among clinical nurses was appreciated by both patients and significant others which rank fifth.

Sixth in the rank was asking for clarification to what had been said, plan and done by the patient which he/she did not understand.

In line with palliative care rendered by clinical nurses it was moderately extent done to collect feedback from the patient and family. This responses was answered seventh by both patients and significant others.

Last in the rank was assessing patients' background, concerns and needs, which is verbally interpreted as moderately extent for both patient and significant others.

Table 2.6

Palliative Care Rendered by Clinical Nurses in terms of Ethical Aspects of Care

	Patients			**Significant Others**		
The nurse:	**Mean**	**VI**	**R**	**Mean**	**VI**	**R**

1. determines the level of patient's involvement in decision making.	3.43	ME	2	3.48	ME	2
2. seeks routinely patient's preferences and documents in the medical record.	3.39	ME	4.5	3.34	ME	5
3. considers patient's preferences and documents in the medical record.	3.29	ME	7	3.26	ME	7
4. advocates the observance of previously expressed wishes, values, and preferences in case patient cannot communicate.	3.16	ME	8	3.10	ME	8
5. assists the physician in giving and explaining information about patient's health condition.	3.39	ME	4.5	3.38	ME	3
6. helps patient understand illness and expectations in the future.	3.33	ME	6	3.31	ME	6
7. protects patient's right to consent or to refuse a treatment.	3.41	ME	3	3.35	ME	4
8. evaluates and help the patient figure out results of care.	3.65	GE	1	3.57	GE	1
Composite Mean	**3.38**	**ME**		**3.35**	**ME**	

Legend: 4.50 – 5.00 = Very Great Extent; 3.50 – 4.49 = Great Extent; 2.50 – 3.49 = Moderate Extent; 1.50 – 2.49 = Least Extent; 1.00 – 1.49= Not at all

Table 2.6 shows the palliative care rendered by clinical nurses in terms of ethical aspects of care. It shows that the nurse evaluates and help the patient figure out results of care with a weighted mean of 3.65 and 3.57 as assessed by patients and significant others respectively. Second in rank was determining the level of patients' involvement in decision making for both patients and significant others.

In the item "protects patients right to consent or to refuse a treatment", the respondents patients rank it third while respondents significant others it rank fourth with a weighted mean of 3.35 and verbally interpreted as moderate extent. On this ethical aspect of care, the present study focuses only to the extent of palliative care rendered in relation to observance of patients' bill of rights. It is expected that it will be supported by the hospital on behalf of the institution, its medical and nursing staff, employees, and patients.

Assisting the physician in giving and explaining information about patient's health condition, it ranks fourth for the respondents patients. However, the respondents significant others, it rank third with a weighted mean of 3.38 verbally interpreted as moderate extent.

Seeking routinely patients' preferences and documents in the medical record ranked fifth for the respondents patient and significant others.

Sixth in the rank was helping patient understand illness and expectations in the future. Considering patient preferences and documents in the medical records rank seventh for both patients and significant others.

According to respondent patients and significant others, advocating the observance of previously expressed wishes, values and preferences in case patient cannot communicate was the least among the items with a weighted mean of 3.16 and 3.10 for both patient and significant others verbally interpreted as moderate extent.

Health care setting whether it is hospital, home based or community and respecting the rights and responsibilities of patients, their families, physicians and other care givers. They must ensure a health care ethics that respect the role of patients in decision making about choices of treatment, consent or to refuse a treatment. Health team must be sensitive to cultural, racial, religious, age, gender, and other differences including the needs of a person with disabilities.

Ethical concerns commonly encountered in palliative care are recognized and addressed, using ethical principles to prevent or resolve ethical dilemmas, including: beneficence or to do good, non-maleficence or do no harm, autonomy or justice, self-determinations, and associated regulatory requirements for truth telling, capacity assessment, confidentiality, assent and permission for people not of legal age to consent, and informed consent and associated avoidance of conflicts of interest. The team recognizes the role of cultural variation in the application of professional obligations, including truth telling, disclosure, decision authority, and decision to forego therapy. Care is consistent with the code of ethics, and the scope, standards, and code of ethics of palliative care practice. The palliative care team aims to prevent, identify, and resolve ethical dilemmas related to specific interventions such as withholding or withdrawing treatments (including nutrition and hydration), instituting do not resuscitate (DNR) orders, and the use of sedation in palliative care. Ethical issues are documented and referrals are made to ethics consultants or a committee (Clinical Practice Guidelines for Quality Palliative Care, 2009).

Table 3

Difference on the Responses on the Palliative Care Rendered by Clinical Nurses as Perceived by the Patients and Significant Others

Palliative Care Rendered in terms of:	t_c	**Sig. Value**	**Decision**	**Interpretation**
Physical	0.061	0.952	Fail to Reject	Not Significant
Psychological	0.625	0.533	Fail to Reject	Not Significant
Social	0.192	0.848	Fail to Reject	Not Significant
Spiritual	0.524	0.601	Fail to Reject	Not Significant
Cultural	0.261	0.794	Fail to Reject	Not Significant
Ethical	0.236	0.814	Fail to Reject	Not Significant

Legend: Significant at sig.value < 0.05

As seen from the table, all computed sig. value are greater than 0.05 level of significance, thus the researcher fail to reject the null hypothesis of no significant difference on the response of the patients and significant others on the palliative care rendered by clinical nurses. This means that the two group of respondents' have the same assessment as to services given by the nurses.

CONCLUSIONS

The following conclusions were based on the findings of the study.

1. Socio economic level is a predictor to health.
2. Cerebrovascular diseases and diabetes mellitus remain on top of list of the causes of morbidity and mortality rate.
3. Clinical nurses render palliative care mainly on physical aspects only; that clinical nurses are not performing the holistic approach of caring; that clinical nurses are the main provider of care to improve patient's quality of life.
4. Therapeutic communication skills is essential to caring.
5. There is no significant difference in the perceptions of patients and significant others to the palliative care rendered by clinical nurses.

RECOMMENDATIONS

Based on the conclusions drawn, the following points are recommended.

1. Health care facilities with advance technology for diagnosis and treatment should be made available, accessible, and affordable to all residents of Batangas City and Bauan.
2. Extensive campaign for health promotion and disease prevention by all health care providers including volunteers may be done. Palliative care may start or establish in the primary health care facilities, through the support of Local Government Units (LGU).
3. The proposed program for clinical nurses and others to enhance knowledge, skills, and attitude on palliative care may be implemented at least twice a year or every 6 months.
4. The College of Nursing may send the nurse educators to intensified palliative care training to later produce students competent in palliative caring.
5. Collaboration between College of Nursing and health care facilities on palliative caring should be established.

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