


The work of palliative care from the perspectives of district nurses: A qualitative study

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Abstract

Aim: To explore the work of palliative care from the perspectives of district nurses with a focus on the strategies they use to achieve positive outcomes for patients.

Design: An exploratory descriptive qualitative study.

Methods: A combination of group and individual interviews using semi-structured interviewing were used to explore district nurses' views of providing palliative care across two large urban community nursing services.

Results: Sixteen district nurse participants were interviewed. Three key themes were identified: "Getting what was needed" involved finding solutions, selling a story and establishing relationships. District nurses sought ways to "Stay involved" recognizing the benefit of delaying discharge for some patients. "Completing a nursing task" was a way of managing time constraints and a form of self-protection from having difficult conversations.

Conclusion: This study highlights the importance of understanding the contextual nature of the practice setting in relation to the provision of palliative care. In doing so, it has revealed the strategies district nurses use to overcome the challenges associated with providing palliative care within a generalist workload.

Implications for the Profession and/or Patient Care: District nurses experience a tension between managing high patient workloads and remaining patient centred in palliative care. Being task focused is a way of remaining safe while managing a high volume of work and is not always a negative factor in the care they provide. However, focusing on a task while at the same time addressing other unmet needs requires a set of skills that less experienced nurses may not have.

Impact: Palliative care education alone will not improve the quality of palliative care provided by generalist community district nurses. The practice context is an important factor to take into consideration when supporting the integration of palliative care in district nursing.

No Patient or Public Contribution: No patient or public contribution was made to this study.

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Reporting Method: We have adhered to the relevant EQUATOR guidelines and used the COREQ reporting method.

KEYWORDS

community, district nursing, nursing, palliative care

1 | INTRODUCTION

The generalist–specialist model of palliative care is designed to ensure that everyone, regardless of diagnosis or care setting, receives some level of palliative care (Quill & Abernethy, 2013). At a policy level, the model assumes that most people will have palliative care needs which can be met by generalist palliative care providers, such as general practitioners or district nurses (Ministry of Health NZ, 2017; National Palliative Care Standards, 2018; Sleeman et al., 2021). It also assumes that all nurses regardless of their practice setting have the necessary skills to relieve symptoms and provide palliative care (Hökkä et al., 2021).

In a number of countries, including the United Kingdom, Australia and Aotearoa New Zealand, the provision of generalist palliative care relies heavily on district nursing services (Christine Coldrick, 2019). District nurses, also known as community nurses, provide care in the community supporting people who have a range of healthcare needs to remain at, or return to, home after hospital admission. In addition to health promotion and patient education, they are also involved in caring for people at the end of life.

The value of district nurses in palliative care has been well documented in the literature (Burt et al., 2008; Offen, 2015). However, district nurses experience significant challenges providing palliative care, including role ambiguity (Griffiths et al., 2007; Offen, 2015) and feeling unrecognized as key providers of palliative care by other healthcare professionals (Burt et al., 2008; Offen, 2015). In addition, the unpredictability and time-consuming nature of palliative care create challenges for district nurse teams who are often working with staff shortages and high clinical workloads (Burt et al., 2008).

Role ambiguity may be, in part, related to the way in which district nurses provide palliative care. Indeed, the nature of palliative care work undertaken by district nurses may differ from that of their hospice nursing colleagues. Firstly, recent evidence suggests that district nurses provide palliative care primarily for people with a non-malignant illness (Robinson et al., 2023) whereas referrals to hospice remain predominantly for people with cancer (Allsop et al., 2018). Secondly, the focus of district nursing practice is often on physical symptoms rather than emotional and psychological support at the end of life (Burt et al., 2008). Finally, a key component of district nursing practice is undertaking nursing tasks, such as providing wound care or catheter care (Charles et al., 2016; Robinson et al., 2022). In contrast hospice nurses have been shown to focus more on providing emotional and psychological care and preparation for people nearing the end of their lives (Robinson et al., 2022). Despite these differences, district nurses clearly have a significant role in the provision

of palliative care in many countries. However, they often struggle to meet the high demand for their services, which often outstrips their capacity to provide that care (Charles et al., 2016; Duncan, 2019). Nevertheless, district nurses consistently report that the work of palliative care is both professionally and personally rewarding (Burt et al., 2008; Dunne et al., 2005; Offen, 2015).

To date, solutions to support district nurses in providing high-quality palliative care have primarily focused on education provision. This approach is aligned with policy and the wider literature which emphasizes the need for specialist palliative care services to educate generalist providers in palliative care (Alshammari et al., 2022). The result of this approach is that palliative care education is considered through a specialist palliative care lens, often with little attention paid to the context in which the care is being provided (Li et al., 2021). Providing palliative care in a non-specialist palliative care setting may require healthcare professionals, including district nurses, to adopt different ways of working in order to meet the needs of patients with a life-limiting illness and their families.

While evidence has highlighted the difficulties of providing palliative care from the perspectives of district nurses (Burt et al., 2008), little is known about the way in which district nurses provide palliative care as they adjust and adapt their practice in response to working in a busy, high-demand setting. Therefore, the aim of this study is to explore the work of palliative care from the perspectives of district nurses with a focus on the strategies they use to achieve positive outcomes for patients and their families. Understanding how district nurses adapt and adjust their practice in response to the demands of their work can contribute to identifying the support they need to provide quality palliative care.

2 | METHODS

2.1 | Study design

An exploratory descriptive qualitative methodology using a conceptual framework described by Hunter et al. (2019) was used to guide the design of this study. Exploratory methodology is used to highlight a little understood phenomenon allowing participants to contribute new knowledge of that phenomenon through their own experiences (Polit & Beck, 2008). A descriptive design aims to collect examples of that phenomenon told through the experiences of participants (Sandelowski, 2010). By combining both approaches, a more rich and nuanced exploration and description of the phenomenon of interest can be achieved (Hunter et al., 2019).

2.2 | Population

The sampling frame consisted of all district nurses (regardless of their experience or seniority) working across two large urban adult community nursing services in Aotearoa New Zealand.

2.3 | Study setting

Combined, the two participating district nursing teams cover a population of over one million people from diverse socio-economic and ethnic backgrounds.

2.4 | Sampling approach

Purposeful sampling was used to recruit participants. Purposeful sampling is considered to be the most appropriate approach in exploratory descriptive design as it ensures that participants have experiences of the phenomenon of interest within different circumstances (Hunter et al., 2019). The concept of "information power" moves the focus away from the amount of data (or sample number) and instead considers the content of the data and its ability to answer the research question. The greater the "information power" a particular sample holds, the lower the number of samples needed; the less information power the sample holds the more samples needed (Malterud et al., 2016). In determining whether the sample size is adequate the researcher must take into account various aspects of the study thought to impact information power including the study aim, sample specificity, applied theory, quality of the interview dialogue and the data analysis strategy (Malterud et al., 2016).

2.5 | Recruitment

Nurse Directors sent letters of invitation to all nurses working in the district nursing teams along with study information introducing the study and asking potential participants to contact researchers if they wish to participate. Information regarding the research team and their affiliations was provided in the participant information. Participants were given the option of participating in a group or individual interview.

2.6 | Data collection

A semi-structured interviewing approach was used to explore participants' experiences of providing palliative care (see Table 1). This is a commonly used approach to data collection in exploratory descriptive design as it supports participants to remain focused in sharing their experiences in a way which reveals the "who, what and where" of that experience (Polit & Beck, 2008; Sandelowski, 2010).

TABLE 1 Interview schedule.

1.	Describe your role as a district nurse in caring for people with palliative care needs.
2.	As a district nurse, what are the challenges you experience in caring for people with palliative care needs? What are the enablers?
3.	Describe how you work with other services such as general practice and hospice? What works well? What does not work well?
4.	What do you think is needed to enable you to provide good palliative care?

Participants were given the choice of participating in a group interview or an individual interview at a time and place that was convenient to them. Individual and group interviews were conducted by two members of the research team (HG and JR), both of whom were experienced researchers and palliative care nurses. Interviews were undertaken between April and May 2021. Individual interviews took, on average, 60 min and group interviews between 6 and 90 min. Group interviews took place at the district nurses' place of work during work hours. Individual interviews were undertaken by phone at a time that was convenient to the participant. All interviews were recorded and transcribed verbatim.

2.7 | Data analysis

A critical realist framework was used to inform the analysis of data. This approach acknowledges the situational reality of each participant, as well as the unseen structures and mechanisms that may impact their experiences of providing palliative care as a district nurse (Williams et al., 2017). An inductive approach using reflexive thematic analysis (Braun & Clarke, 2019) was used to identify key themes from the data. Familiarization with the data was undertaken through reading and re-reading all interview transcripts to become immersed in and familiar with their content. An initial coding framework was developed by HG and presented to the research team for further discussion. A sub-set of interviews was given to each member of the team to code using the coding framework as a guide. Finally, a review of developing codes and themes was undertaken by the research team as a whole to inform the development of the final analysis framework. To ensure a rigorous integration of group and individual data occurred, movement back and forth between the different data types took place throughout the analysis (Lambert & Loiselle, 2008).

2.8 | Ethical considerations

Ethical approval was granted from the Auckland Health Research Ethics Committee (Ref: 19CEN78AM04) followed by locality approval from each study site.

2.9 | Rigour and reflexivity

The Consolidated Criteria for Reporting Qualitative Research (COREQ) was followed (Tong et al., 2007). The research team consisted of nurse leaders, palliative care nurse researchers and academics. All interviews were undertaken by experienced palliative care nurse researchers (JR and HG).

3 | FINDINGS

Sixteen nurses participated in the study (see Table 2). Three chose to have an individual interview as they were unable to attend the scheduled group interviews. The remainder participated in one of two group interviews. This number of interviews was considered sufficient to achieve “information power” and provide rich, contextual data to meet the aim of the study (Malterud et al., 2016). The average age of participants was 58.5 years (range 33–66 years), most were female ($n=15/16$) and most ($n=11/15$) identified as New Zealand European. Participants reported a significant amount of nursing experience, ranging from 10 to 42 years (average 30 years). In addition, many participants had a substantial amount of experience working in the community, ranging from 4 to 40 years (average 14 years).

Three key themes with associated sub-themes relating to the palliative care work of district nurses. “Getting what was needed” required district nurses to find solutions, sell the story, establish relationships with colleagues in other services and be creative in their practice. They also identified the importance of “Staying involved” and actively sought ways to achieve this including being able to

identify the benefit of staying involved for patients and seeking out a nursing task to delay discharge from the service. Finally, although district nurses were aware that they were often involved in patient care because of the need to complete a nursing task, they were able to see the benefits of this focus in their practice including managing time constraints, self-protection and the task being a reason for referral to their service.

3.1 | Getting what was needed

Many participants talked about identifying strategies to get what was needed for patients and families. This was often in response to the district nurse experiencing difficulties in accessing resources they needed to achieve a positive outcome for patients. In doing so, district nurses demonstrated knowledge of the resources available in other services and found solutions to get what was needed. This involved negotiating support from services such as hospice. The hospice access to 24/7 medical support for prescribing medication was described by one participant. The need to get medication changed quickly and the barriers associated with accessing the GP at the end of the day or over a weekend were evident:

And it's sometimes reassuring just to have hospice involved so you know you can get your medication fast when things changed. 'Cause inevitably it's late in the day or in the weekend. That's one thing, because they've always got a doctor.'

(Group interview 2)

TABLE 2 Participant information.

Age	Ethnicity	Gender	Overall nursing experience	Community nursing experience	Data collected
58	NZE	Female	35 years	5 years	Interview
33	NZE	Female	12 years	4 years	Interview
61	NZE	Female	41 years	5 years	Interview
56	NZE	Female	20 years	6 years	Group interview (A)
N/S	Asian	Female	N/S	5 years	Group interview (A)
50	NZE	Female	28 years	12 years	Group interview (A)
63	NZE	Female	40 years	25 years	Group interview (A)
50	Asian	Female	10 years	5 years	Group interview (A)
59	NZE	Female	40 years	20 years	Group interview (A)
44	NZE	Male	20 years	5 years	Group interview (B)
60	NZE	Female	42 years	20 years	Group interview (B)
64	European	Female	40 years	23 years	Group interview (B)
34	Asian	Female	34 years	10 years	Group interview (B)
50	Asian	Female	30 years	7 years	Group interview (B)
59	NZE	Female	39 years	33 years	Group interview (B)
66	NZE	Female	20 years	40 years	Group interview (B)

Abbreviations: N/S, not stated; NZE, New Zealand European.

When negotiating with other services to get what was needed, participants described how they had to “sell the patient story” often to multiple people. While this was often time-consuming, participants described how they remained focused on what the patient and family wanted. For example, for one participant, the focus on achieving adequate symptom management while supporting the patient to remain at home motivated her to keep phoning different people until she got what was needed.

And I, he had a referral to hospice but they hadn't seen him, and I desperately didn't want to, so I tried the GP and it was a locum, can it wait 'til Monday and I said no it can't. I want pain relief for this man, we can't even move him.' He can't swallow anymore, you know, he's on oral tabs and things. And so I rang hospice and said look this is desperate. Oh send him into ED.

And it took about 6h and basically then I tried to get hold of the GP. And it was just a long, millions and millions of phone calls. And in the end the hospice GP agreed to go. (Group Interview 2)

Success in getting what was needed for patients was often related to having pre-existing relationships with nursing colleagues from other services. Some participants described relationships with colleagues from other services which had been developed over many years. These relationships were helpful for district nursing getting what they needed for their patients. A sense of trust between colleagues was a motivator for a hospice nurse to “stay in the background” supporting the district nurse to remain as the primary provider.

They [the hospice] are happy for us to remain the primary provider. I think for us, X and I anyway, it's like we know most of them there [the hospice nurses]. Well not the new ones that much, so I think they trust what we're doing and so they're quite happy to be in the background if they're not really needed. (Group interview 1)

However, while recognizing the value of these relationships, many participants were overwhelmed trying to balance day-to-day work with maintaining relationships with colleagues from other services. They were creative in ideas to improve the relationships with their service partners and the value this would have on patient outcomes. However, they were often frustrated in not being able to implement these solutions or see them through to fruition. One participant described how the pressures of getting through the day-to-day work prevented them from engaging in building relationships with nursing colleagues from other services.

And something we talk about when we talk about our ideal nursing is, for us it's, you know, as charge nurses as well or even senior staff that we have within our team, having the opportunity to go and meet with the practice

nurses and GPs and everything, and building those relationships with them. But, you know, sometimes you just sit there and you say you wish you could do that, but then when you look at the time and workload and resources it's near impossible. (Group interview 1)

3.2 | Finding ways to stay involved

Many participants recognized the unique needs of patients with advanced chronic disease and were able to identify what was needed in order to support them to remain at home. This included the benefits of getting involved early, particularly as other services would not get involved unless the patient was imminently dying. While district nurses recognized a need to stay involved, they were not always supported to do so from an organizational perspective. However, they would find ways to do so especially if there was no other service available.

Heart failure's a common one for us. We have a patient with heart failure and maybe came to us for wound care or whatever and we've healed it. They won't, hospice won't pick it up because they're not actively dying. (Group interview 1)

Participants also recognized the risk of discharging patients with advanced chronic disease from their service when the nursing task was no longer required. Discharging patients prematurely prevented them from providing the necessary anticipatory care and planning for future exacerbations of illness. Some participants highlighted how they would try to find a reason to keep people from being discharged.

And we can't keep them because they don't have a task but they still need more support in terms of managing and making them stable for their heart failure.

If you've got a device though, we'll keep you on the service. So if you're a palliative client with a catheter or enteral feeding or a trachea you always stay on the service, 'cause you've got a device and a need for something consumables.' But if you haven't got a device then we are quick to discharge. (Group interview 2)

Others described various strategies to keep people on their books, such as continuing to review for wounds that had almost healed. This enabled them to support patients with significant health needs to remain in their own home. In addition, it gave them an opportunity to facilitate effective anticipatory planning with patients and families, some participants expressed how they had a role in avoiding or preventing a hospital admission.

And you'll be proactive with dealing with those things. Knowing what's coming you can actually prepare that

family. But also you can be troubleshooting so that you do hospital avoidance stuff. And look at reversibility of things, and stuff. (Group interview 2)

Staying involved for a longer period was seen by participants as an opportunity to establish relationships with the patient and their wider family. This was seen by some participants as a way of them being able to use all their nursing skills. Indeed, participants discussed how staying involved positively impacted their nursing practice and their ability to provide better patient care.

It's such a shame because it's like it creates a dumbing down of community nursing. 'Cause, you know, when you get a lot more involved it makes you think more and you work at a different level.' (Group interview 1)

3.3 | The problems (and benefits) of just a nursing task

Nursing tasks such as urinary catheter care, wound dressings and intravenous medication administration were seen by many participants as an important role for district nurses. Referrals to the district nursing service, from general practitioners and hospice colleagues were frequently predicated on the need for a nursing task. One participant described how a GP would refer them to administer an enema even when hospice nurses were visiting to provide symptom management. This was often seen by participants as referrers not understanding or valuing the contribution they could make in terms of palliative care.

They're referring to us for the tasks. And for our point of view, we know that hospice won't do hands on nursing care. So we would go in, even to the extent where sometimes, not always, but we go in to flush a catheter, give an enema in the middle of symptom management. They're not, you know, they're not always administering enemas. It's prescribed by the GP and then we go and give it. (Group interview 2)

However, providing nursing tasks was considered both a positive and a negative aspect of their role as district nurses. Being seen as experts in nursing tasks meant they received referrals that hospice would not get. While the task enabled them to make initial contact with the patient, participants expressed how their care became more than just completing the task. For example, one participant described how providing support for wound care gave her an opportunity to build on the relationship and complete a full palliative care assessment.

So you might have a palliative patient that you're going in to do a wound care on, and they're a palliative patient. So you can actually still be doing the head to

toe assessment while attending to the wound care. And if you've got a good relationship, you've established rapport with that person, you've known them for a while. (Interview 3)

However, there was no doubt that many participants struggled to move away from a task-focused approach in their practice. This was often as a result of high workloads and limited time to get the required work completed. One participant described a sense of powerlessness in being able to stop the negative impact of working in a task-focused way on her practice.

It's just like go in, do a task, and it's almost like you could have a spreadsheet on what to do, you know. And it's just mindless, a lot of it. And so it's like a catch 22, because the skill level decreases over time because you're not encouraged to, you know, do a good job really. And so you just get, you forget stuff and it's just like it gets worse and worse. And then before you know it, even though you go into a job swearing you're not gonna be that person, you end up being that person just doing a mindless task. Because that's how the job directs you at that point in time. (Group interview 1)

Yet, some participants described that, with skills, knowledge and an established relationship with the patient, the nursing task could be provided in a way that integrated a holistic approach to patient and family care. One participant described how she could attend to a nursing task while at the same time complete a full assessment of the patient. Role modelling from expert nurses was seen as a potential strategy to improve the skills of less experienced nurses.

So that loss of expertise then also leads to a lack of role modelling; people seeing you go in and see someone with a palliative wound I'm also doing a head to toe assessment, and I'm asking them about their pain, and their sleeping, and their bowels, and how they're eating etc. Versus a young nurse being allocated to go and see a palliative patient with a wound will focus on a wound, and not necessarily think about what a palliative person's requirements may be. And not just of course the patient, but looking wider in the home at what the family need as support or reassurance. 'Cause the conversations that you have in the driveway after you've left the person in the home with the family member are equally valuable.' (Interview 3)

Although working holistically was viewed as the ideal by many participants, remaining task focused kept them safe and was a way of managing the workload in the allocated time. Focusing on the tasks at hand was a successful strategy for some participants.

You need a task, so it's not that holistic thing. When we're looking at the patients we do holistic because we've got more time allocated. But that issue, you're dropping them off basically. (Group interview 2)

Remaining focused on the nursing task was seen as a self-protection strategy for less experienced nurses. By concentrating on the particular task that needed to be completed during a home visit, the nurse was able to avoid sensitive conversations which might have resulted in strong emotions which they felt ill-equipped to respond to.

And lack of knowledge just even from a nursing background, not even from an oncology background, but a general nursing thing means they haven't got the person to be open to dealing with whatever they come across in the palliative situation. And so they go in and they just tick, tick, tick off a task. (Group interview 1)

4 | DISCUSSION

To the best of the authors' knowledge, this is the first study to explore the various strategies district nurses integrate into their practice to overcome the barriers to providing palliative care. In doing so, this study takes into account the demanding and busy environment that district nurses work within. Understanding the work environment and the strategies adopted by district nurses to provide positive outcomes for patients with palliative care needs is an important consideration when investing in the growth and development of community nursing services.

A key finding from this study was the unique in which district nurses got what was needed for their patients. This involved knowing what resources other services had access to as well as negotiating with other services to access what they themselves could not provide. Service restrictions led to district nurses being creative in their practice as they sought solutions to the problems they faced in providing patient care. However, many participants focused on the problems that arose rather than celebrating the solution they found. This preoccupation with the problem was exacerbated by the need for district nurses to frequently "sell the story" as they advocated continually for the patients they cared for. The success of selling the story was often determined by the relationships district nurses had with their colleagues from other services. This finding is consistent with previous research demonstrating that inter-professional collaboration is key to meeting the palliative care needs of people nearing the end of life (Pornrattanakavee et al., 2022). Furthermore, having trusting relationships with colleagues has been shown to have a positive impact on job satisfaction for nurses as well as improve patient safety (Labrague et al., 2022). These relationships are built on having a common goal to take care of patients while also providing support for one another (Kristoffersen, 2021). Findings from this study highlighted how district nurses valued the trusting relationships they had with nursing colleagues from other services. This had a profound

impact on feeling valued and in their ability to achieve a positive outcome for patients with palliative care needs.

An essential element of good palliative care is attention to the prevention of pain and other symptoms at the end of life (Seow & Bainbridge, 2018). Supporting patients as they plan for the end of their life requires consistency in the services they receive. Many participants in this study recognized the need to stay involved with patients for longer periods of time sharing how they would find ways to remain involved even when the task had been completed. Episodic care is exacerbated by a focus on nursing tasks which is evident in district nursing practice (Nagington et al., 2013). Workforce Standards for District Nursing in the United Kingdom highlight that without the ability to discharge cases, the demand for district nursing services will become unremitting and unsustainable (The Queen's Nursing Institute, 2022). Equally, they go on to say that district nurses must be enabled to provide patient-centred, individualized, holistic care that is not driven by a "time-task" approach. While there was evidence in this study of district nurses being task focused in their work, this was not always seen as a negative approach to practice. Indeed, for some participants being task focused helped them to get through the overwhelming volume of work. For others focusing solely on the task at hand kept them safe in their work, particularly for less experienced nurses.

Feeling overwhelmed by a demanding workload can challenge nurses' sense of safety in their practice (Pérez-Francisco et al., 2020). Nurses are aware that overcrowded and demanding clinical environments risk patient safety (Eriksson et al., 2018). Furthermore, feelings of being out of control as a result of unrelenting demanding workloads can have an emotional toll on nurses (Eriksson et al., 2018; Pérez-Francisco et al., 2020). It is not surprising, therefore, that in this study district nurses found ways to maintain a sense of control in their work. Focusing on key tasks that need to be completed, even when this risks a patient-centred approach, was described by participants. This was a useful strategy for district nurses to manage and take control of the workload. In addition, less experienced district nurse participants used a task-focused approach to protect themselves from the sensitive conversations that might occur when caring for someone nearing the end of their lives.

The value for patients and staff of maintaining a patient-centred approach to practice has been well documented. Moving from a focus on "technical tasks" to valuing the relational aspects of nursing care has shown to have a positive impact on job satisfaction as well as patient outcomes. However, maintaining patient-centred practice in busy clinical environments which emphasize efficiency and completion of tasks can be challenging (Sharp et al., 2018). Furthermore, patient-centred care requires nurses and organizations to have the skills to engage in partnerships and shared decision-making with colleagues and patients. Indeed, evidence has shown that less experienced nurses need support to integrate person-centeredness into their work including development of interpersonal skills and professional competence (Tiainen et al., 2021). Findings from this study showed how experienced nurses were able to remain patient

centred while still completing the nursing task. However, this relied on a level of skill and experience that not all nurses had. The set of knowledge and skills required to be patient centred in palliative care is substantial including having the communication skills to engage in conversations about death and dying (Brighton & Bristowe, 2016). For district nurses this becomes more complex as they juggle the 'busyness' of the work setting.

This study has added to what is already known about the service limitations experienced by district nurses and the impact these have on their ability to provide palliative care (Burt et al., 2008; Robinson et al., 2022). Findings from the study have also highlighted the strategies district nurses adopt in their practice to overcome these service limitations. It is clear that education alone will not address these issues. Instead, the practice setting and the strategies adopted by district nurses to overcome the service limitations must be taken into account when designing and supporting an integrated generalist-specialist model of community nursing care.

5 | STRENGTHS AND LIMITATIONS

The study was conducted across two study sites, both situated in a major urban area. This may limit generalizability of the findings to other populations, for example, those living in rural or remote areas. Furthermore, participants were likely to be nurses who had an interest in providing good palliative care, therefore, bringing some potential influence by the researchers into the data. However, despite these limitations, there are learnings that can be taken and applied across other settings including the need to contextualize nursing practice when considering ways of improving the provision of palliative care outside the specialist setting. Participation in either an individual or a group interview was offered to participants. This may have had an impact on the type of data collected; however, a focus on integrating both data types through the analysis process was adopted.

6 | RECOMMENDATIONS

All nurses need competencies in providing palliative care. However, there is little evidence on what specific level of palliative care competency is required (Hökkä et al., 2020). Understanding the practice environment and the challenges district nurses face in providing palliative care in a generalist palliative care setting may help to understand the competencies required for district nurses. The increasing volume of work being managed by district nurses worldwide has to be taken into account when identifying ways to improve the care of people living at home with palliative care needs. Furthermore, service rules, such as admission and discharge criteria, can be a barrier for nurses to provide patient-centred care. Supporting nurses to be creative and flexible in responding to current and anticipated patient needs is key. Finally, identifying strategies to support the development of skills which enable nurses to focus on key nursing tasks while still remaining patient centred is needed.

7 | CONCLUSION

The findings from this study have highlighted the importance of understanding the contextual nature of the practice setting in relation to the provision of palliative care. A better understanding of the challenges associated with providing palliative care within a generalist workload is needed. Given that most people will be cared for by generalist palliative care providers such as district nurses, education must take into account the limitations of the setting in which the care is being provided.

AUTHOR CONTRIBUTIONS

All authors have agreed on the final version and meet at least one of the following criteria (recommended by the ICMJE): (1) Substantial contributions to conception and design, acquisition of data or analysis and interpretation of data; (2) drafting the article or revising it critically for important intellectual content.

Jackie Robinson: Study design, Data collection, Data analysis, Writing. Hetty Goodwin: Data collection, Data analysis, Writing. Lisa Williams: Data analysis, Writing. Natalie Anderson: Data analysis, Writing. Jenny Parr: Data analysis, Writing. Rebekah Irwin: Data analysis, Writing. Merryn Gott: Study design, Data analysis, Writing.

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CONFLICT OF INTEREST STATEMENT

No conflicts of interest have been declared by the authors.

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DATA AVAILABILITY STATEMENT

The data that support the findings of this study are available from the corresponding author upon reasonable request.

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